Notions of community, professionalism and volunteering in community-centred, public health approaches: a qualitative case study

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Σας αγαπώ απεριόριστα και μου λείπετε κάθε μέρα.

Abstract

Background: Community-centred approaches are increasingly popular in public health practice. The use of volunteers as part of such approaches is common, as it recognises people as assets within communities; assets that can help improve community public health and wellbeing outcomes and aid community development.

Case study: Given the widely accepted importance of early years in providing children with the best possible start in life, and in recognition of the need for a shift to bottom-up approaches, a community volunteer programme was designed and implemented in a deprived ward of Stockton-on-Tees in the North East of England. Using this programme as a case study, this PhD thesis aimed to explore what volunteering is and how it works in a community-centred volunteer programme, through examining professionals', volunteers' and parents' accounts.

Methods: Qualitative intrinsic case study methodology was used. Rich qualitative data were collected through forty-four interviews, five focus groups, observations and documents.

Findings: This study contributes to current understandings around community, professionalism and volunteering within community-centred approaches. A profound lack of a shared understanding of the term 'community' amongst different stakeholders was identified. It was also found that volunteering presents development opportunities for disadvantaged community members and particularly asylum seekers. Their strong reciprocal feelings and their willingness to volunteer as well as the plethora of human, social, cultural and political capital they can offer presents opportunities to widen the volunteer workforce. The findings also emphasised the detrimental effect tensions between professionals and volunteers can have on a community-centred approach.

Conclusions: This PhD has implications for theory and research. Equally, it has implications for public health practice through the development of a model which can be used as a tool to design community-centred approaches. This model, informed by literature, previous research and the findings from this thesis, can be valuable for commissioners, practitioners, professionals, volunteers and the wider community.

Declaration

I declare that this thesis has been composed solely by myself and that it has not been submitted, in whole or in part, in any previous application for a degree. Except where stated otherwise by reference or acknowledgment, the work presented is entirely my own.

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List of acronyms and abbreviations

AFS	A Fairer Start
BLF	Big Life Families
BME	Black and Minority Ethnic
CAF	Common Assessment Framework
CCG	Clinical Commissioning Group
DBS	Disclosure and Barring Service
EYFS	Early Years Foundation Stage
FSVP	Fairer Start Volunteer Programme
JSNA	Joint Strategic Needs Assessment
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
UK	United Kingdom
VCSE	Voluntary, Community and Social Enterprise

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1. Chapter One: Introduction

This thesis sets out to explore the introduction of a public health early years programme in one English local authority area with high levels of deprivation. The programme formed part of an effort to improve the health of the very youngest children, with the view to tackle and prevent health and educational inequalities and give children a fair start in life. A complex intervention was designed to engage parents of children living in poverty and was delivered by an external body, using volunteers as a key part of the delivery workforce. Using case study methodology, this thesis reports on the complexities of such a programme, particularly around the use of volunteering within community-centred approaches in public health. The recent policy document (Department of Health and Social Care, 2018) from the Secretary of State for Health and Social Care, Matt Hancock, emphasised the need for prevention, early intervention and use of community approaches to improve the nation's health. This study is therefore not only timely, but furthers knowledge and adds to the evidence base for early years intervention programmes as well as the adoption and implementation of community-centred approaches.

This introductory chapter of the thesis will provide the wider background of the study, situating it in the context of community-centred early years intervention. It will first provide the rationale for early years intervention, followed by the rationale for community-centred approaches and volunteering. It will then outline the approach adopted for this study, followed by the aim and research questions of the PhD. Lastly, the structure of the thesis will be outlined.

1.1. Study background

Providing children with the best start in life has been a priority in governments' agendas over the past decade. Early years intervention has been repeatedly recognised as the most appropriate way of ensuring that every child has the best chance to achieve their full potential

(Axford et al., 2015b). A review, commissioned by the government and conducted by Field (2010) concluded that, in the constant battle against child poverty, learning and development opportunities for children, good parenting and family background are more important than financial resources in terms of preventing adulthood poverty (Field, 2010). The review also identified that the first five years of a child's life are the most critical, and intervening in a child's early years is pivotal in order to decrease and prevent poverty. The need for parents to provide children with opportunities for cognitive, communication, social and emotional development was also emphasised (Field, 2010). Although comprehensive in terms of making the case for early years intervention, the review lacked details on the evidence around implementation of such initiatives, particularly around their cost effectiveness and long term health and social benefits.

In order to fill that gap, another government-commissioned review conducted by Labour Party MP Graham Allen (2011), discussed the financial benefits of early years intervention. In the report, Allen provided evidence, which suggested that focusing on improving social and emotional development during early years can have significant social and economic benefits in the long term (Allen, 2011a). He also suggested that late intervention is more costly than early intervention and urged the government to invest in early years prevention programmes (Allen, 2011b). Other reports both independent and government commissioned, add to this evidence with regards to the benefits of early intervention for children.

An independent report examined the effectiveness of the Early Years Foundation Stage (EYFS), a framework, which sets standards for the development, learning and care of children from zero to five years old. Tickell (2011), in her review, argued that parental education, occupation or socio-economic circumstances are not as important as a quality early years environment and advised that professionals working with children aged zero to five years old

should work with parents in order to create such a setting. Furthermore, she emphasised that early intervention and collaboration with parents can facilitate the intellectual and social development of a child (Tickell, 2011). Similarly, Munro's (2011) report on child protection highlighted that parental behaviours such as child abuse and neglect could potentially have an effect on a child's development and should be addressed by intervening early. She recommended that more preventative services are necessary for children and young people (Munro, 2011). In addition to these reviews, other documents have emphasised the significance of early years service provision for the future development of children and have concluded that providing children with the best start in life is key in reducing social and health inequalities (Department of Health, 2010; Marmot, 2010).

Whilst the above mentioned documents consider early years interventions to be pivotal in addressing poor outcomes for children, both educational and socio-economic, some debate its potential issues (Statham & Smith, 2010). It has been argued that there is lack of evidence to demonstrate that early intervention initiatives and programmes actually make a difference in long-term educational and socio-economic outcomes (Wolstenholme, Boylan, & Roberts, 2008; Plimmer & van Poortvliet, 2012). In an attempt to explain the lack of evidence, proponents of early years intervention have argued that it stems from the fact that, in order for an early years intervention initiative to produce results, it needs to be in place for a number of years, which is rare due to funding issues (Anderson, 2013). This is an issue for two reasons; firstly there is a need for an intervention to be sustained over a long period for the best results to be achieved. For example, a brief, three-month intervention is less likely to be as effective as a three-year early intervention programme. Secondly, the outcomes of an early intervention programme need to be tracked over a number of years to determine effectiveness. Anderson (2013) called for funding for longitudinal research so that the impact of early intervention programmes can be explored over the lifetime of a child. Another issue with early intervention

programmes is that the economic benefit and the long-term gains is often derived by a different sector in budgetary terms. For example, investment in early intervention programmes from an education body is likely to produce significant savings for the NHS in subsequent years. However, economic evaluations of such programmes rarely explore savings in other sectors thus not providing the full extent of the benefits of early intervention (Allen, 2011; House of Commons, 2018).

Another criticism of early intervention programmes is that they address issues by supporting individual children, young people or families without addressing the wider societal problems that lie behind individual needs such as poverty, access to education and healthcare or employment opportunities (Moris & Barnes, 2008). Many believe, however, that by addressing individual needs, early intervention can prevent the wider societal issues from perpetuating through generations (Allen, 2011a; Allen, 2011b). It is critical, nonetheless, that the provision of early intervention programmes is universal and that financial obstacles can be overcome (Allen, 2011a).

Despite these arguments regarding the shortcomings of early years intervention, it is now part of governments' agendas and, as a result, a number of national initiatives to implement early intervention have been developed. Perhaps as a realisation that the years of late intervention were neither successful nor inexpensive, successive governments since the Coalition government of 2010 have turned their attention to early intervention.

Reducing child poverty, reconfiguring health services by increasing the number of Health Visitors and ensuring that disadvantaged children are targeted by children's centres, have been priorities for both David Cameron's and Theresa May's pre Brexit governments (Axford et al., 2015a). A recent key policy decision was the transfer of 0-5 children's commissioning of public health services for children from NHS England to local authorities, in force from October,

2015. This decision was made to ensure that future commissioned services are sustainable and with the view of providing the best outcomes for 0-5 years old children. Responsibility for services included in the Healthy Child Programme 0-5 (HCP), such as health visitors and Family Nurse Partnership (FNP), were also transferred to local authorities (Department of Health, 2015). These policy decisions may only be relevant to the UK; the shift however, from late to early intervention can be observed worldwide.

A number of early years intervention initiatives have been established worldwide, with research around these initiatives primarily focussing on answering questions about effectiveness (Black, Walker, Fernald, et al., 2017). Some research has shown that early intervention programmes can be effective in improving child development (Rao, Sun, Chen and Ip, 2017). Programmes such as Head Start, Early Head Start and the Chicago Child-Parent Centres have been thoroughly evaluated (Merritt & Klein, 2015). Broadly, the main outcomes of these programmes included improving language development by working intensively with parents and providing them with educational resources. Parents were provided with services such as continuous intervention and child development assessments, family support and counselling (Benzies et al., 2014). Research into the effectiveness of these programmes demonstrated that children showed improved language development (Merritt & Klein, 2015). Moreover, a similar programme in Canada which included early learning, provision of nutritional advice and parental psychosocial resources, showed positive effects, not only in terms of children's language development, but also parental wellbeing (Benzies et al., 2014).

Although the short-term effectiveness of some early years intervention programmes is generally accepted, debate exists around their long-term effectiveness. Whilst some evidence exists to support the long-term effectiveness of early intervention to prevent anti-social or delinquent behaviour (Webster-Stratton, Reid, & Hammond, 2001; Yoshikawa, 1995), the

evidence around the long-term effectiveness of early intervention initiatives that target child development is inconclusive (Barnett, 1995; Burger, 2010).

Despite the lack of consensus around the effectiveness of early years intervention, many local authorities, government bodies and voluntary organisations opt for their implementation. With this in mind, there has recently been a suggestion that a community-centred approach to early years interventions, partly through volunteering, can play a big role in improving both developmental outcomes for children and in improving communities. This is explored further in the next section.

1.2. Volunteering and early intervention

In addition to the recognition that early intervention may be more effective financially and in terms of its outcomes, the approach which is taken to design, implement and evaluate such programmes has also seen a shift. In contrast to the traditional top-down approaches, it has been argued that bottom-up approaches can potentially be more effective. Thus, community asset-based approaches for early years interventions are being encouraged by governments and local authorities. The term "community approach" can have different meanings depending on people's understandings. As South & Stansfield (2016) suggest, from a public health point of view, community-based approaches refer to approaches which aim to utilise the strengths within a community, empower individuals and as a result improve population health and wellbeing (South & Stansfield, 2016). According to the same authors, and as will be shown in the third chapter of the thesis, this is not a new concept; however, the recognition that health cannot be improved in isolation and that the wider determinants of health need to be addressed by people at all levels, is relatively novel (South & Stansfield, 2016). This is in agreement with the wider arguments around the social determinants of health, which call for a shift in the way

public health is understood, to account for the social circumstances that influence it (Bambra et al. 2010).

In addition, it is now widely acknowledged that community assets, in the form of social networks, local knowledge and, most importantly, people's skills can be used to improve health outcomes (South, Stansfield, & Fenton, 2015). This is also evident in a King's Fund report which suggests that local authorities need to build social capital and utilise assets within their communities to improve health and tackle health inequalities (Buck & Gregory, 2013). Thinking along the same lines, it comes as no surprise that the inclusion of members of the public in early years interventions is nowadays common (Woodall, White, & South, 2013; Frost, Abbott and Race, 2015). Advocates of volunteering in early years interventions have stated that volunteers can improve relationships between professionals and the community, increase the levels of engagement with early years services, improve sustainability of service provision and allow professionals to focus on families and children that require more intensive support (Jackson, 2012). Particularly in times of financial austerity when funds are scarce, it can be argued that the more expensive professional resources should be saved for those with the deepest or most complex needs whilst those with lesser needs can be supported by volunteers potentially following training or under close professional supervision (Jackson, 2012). Moreover, utilising local expertise can improve professionals' understanding of the populations' needs and therefore tailor their messages to meet those needs. The insight that volunteer members of the public provide can also help professionals understand the issues and barriers that people face which can, again, lead to better support for these people (South & Sahota, 2010). In addition, volunteers or para professionals can be more acceptable care or treatment givers to those who are seriously disadvantaged than professionals would be, because the latter are considered to be distant and out of touch with their lives (Naylor, Mundle, Weaks, and Buck., 2013). Involving volunteers, therefore, in community-centred initiatives can be

valuable both as a standalone approach with the view to empower and mobilise assets as well as alongside professional services already delivered in a community as a means of improving professionals' relationships with the community.

The involvement of volunteers in early years interventions has been particularly common in developing countries over the years, with promising results in terms of effectiveness (Were, 2002). Previous studies have demonstrated that volunteers were successful in recognising low birth weight of babies and could provide sufficient advice and support to families in order to increase the child's weight (Amano et al., 2014). Furthermore, studies have shown that, following peer supporters' involvement in maternal and neonatal care in Kenya and India, both community and self resilience were improved (Arole & Arole, 1975; Were, 2002; Lehmann and Sanders, 2007). However, as these studies were undertaken in developing countries, and given that their outcomes involved infant mortality and disease control, their applicability to a UK setting might be questionable.

Studies in the UK context have also found that volunteers can improve individual and community health. An evaluation of community projects that were delivered in Yorkshire and Humber in England as part of the Altogether Better programme was carried out. The programme aimed to improve physical activity, healthy eating, mental health and general wellbeing. The evaluation highlighted that volunteers were successful in helping integrate people into the community and that they promoted social cohesiveness (Woodall, White, & South, 2013). However, it was challenging to identify the impact of volunteers on health outcomes as, according to the study, this takes time and, at the time of the evaluation, the intervention had not had enough time to show any tangible impact on health or behaviour change (Woodall et al., 2013). Nevertheless, the same study identified numerous benefits for volunteers as a result of their involvement in the project. Increased self-esteem, confidence and

wellbeing, as well as opportunities for education or employment, were the most commonly reported benefits (Woodall et al., 2013). These findings are in line with other studies that have emphasised the benefits of volunteering including: employability and self-confidence (Jackson, 2012), psychological wellbeing and self-reported health (Piliavin & Siegl, 2007). Another important aspect of volunteering in early years interventions that is under-researched is the preference of mothers. Some studies have found that mothers prefer peer support rather than health professionals' support (Glenton et al., 2013; McInnes & Chambers, 2008), but there is not enough evidence to form a consensus.

Despite the apparently positive outcomes for volunteers and the communities they volunteer in, some scepticism exists regarding the potential risks of volunteering (All Party Parliamentary Sure Start Group, 2013). Service provision could be compromised as a result of involving unqualified/untrained individuals (All Party Parliamentary Sure Start Group, 2013). However, it seems fair to argue that volunteering in early years interventions is an approach that continues to be adopted nationally (Woodall, White, & South, 2013). Whether it is as a result of austerity measures and the need to replace paid with unpaid labour, or whether it represents a genuine shift in seeing communities as full of assets rather than deficits, there are currently numerous early years interventions utilising volunteers in the UK (Mcleish, et al., 2016).

One of them was implemented in the North East of England, in Stockton-on-Tees and was the setting of this PhD study.

1.3. Researcher background

Before presenting the approach that was used for the study, it is essential to write a brief section which puts me, the researcher, in the context of my research, reflects on my own background and bias and how these shaped my research. This is essential for any qualitative study as it is

acknowledged that, despite all efforts to be objective and fair to my participants and their accounts, these findings were ultimately shaped by me.

I am a female researcher with a background in psychology. I hold a BSc (Hons) in Psychology and Counselling, a Postgraduate Diploma in Psychology, an MSc in Health Psychology and I am currently finishing a PhD in Public Health. I worked as an evaluative researcher for the Centre for Health and Social Care (CHASE) at Teesside University prior to starting and during this PhD. I have conducted evaluations on numerous public health initiatives targeting children and young people, the elderly and the general public. It was therefore with an evaluative mind-set that I embarked on the journey of this PhD.

I am also a Greek national which I believe is of relevance to this study. I was unaware of the UK early years system and therefore I approached it as a new subject, without pre-conceived ideas about or experiences of it. This helped me ask "naïve" questions around the system within which the volunteer programme was implemented. I also believe that the fact that I am not a UK national also meant that many of my (non-British) participants could relate to me as non-UK nationals in the UK. Indeed, many conversations as part of the interviews were around their experiences of having moved to a different country with many asking about the circumstances that led to my move and my experiences in the UK. I believe that this helped me build rapport with some participants.

With regards to my previous knowledge and experience of the subject, I have volunteered previously as an assistant psychologist working for six months in a hospital for children with cancer. I volunteered there as an undergraduate, because it was proposed by my degree supervisor as an activity that would help me secure future employment as a psychologist. Despite the fact that my volunteering started as an "investment" in my future, I found it

particularly rewarding. Hence, when the opportunity arose to research volunteering in more depth I felt that I could do it justice given my past experiences.

With regards to community work, I previously worked in the community with young people as a youth worker. Although I only worked as a youth worker for a year, this experience also shaped my thinking around community work, particularly because I worked with young volunteers who volunteered to help their peers with issues such as substance misuse, smoking and sexual health. These experiences have inevitably shaped my view on volunteering and its different aspects. I have worked with volunteers who had to volunteer in order to continue receiving their Jobseeker's allowance and I have worked with volunteers who were simply passionate about youth work. Therefore, I understand why some misconceptions around volunteering and the motivations behind it exist.

This brief reflection on myself, my background and bias aimed to allow the reader of this thesis understand the person behind this research before presenting the study itself.

1.4. Study approach

This PhD study uses a volunteer programme as case study to explore volunteering when used as part of a public health, complex intervention in order to improve health and educational outcomes for children, health outcomes for families and, more broadly, aid community development.

Due to the complexity of this particular volunteer programme, both in terms of its intended outcomes and the context in which it was implemented, there was a need for unconventional thinking around its exploration. As Hawe, et al. (2009) note:

> *"Conventional thinking about preventive interventions focuses over simplistically on the "package" of activities and/or their educational messages. An alternative is to focus on the dynamic properties of the context into which the intervention is introduced." (Hawe, Shiell, & Riley, 2009)*

These authors suggest that schools, communities and worksites can be thought of as complex ecological systems (Hawe et al. 2009). A new intervention will be a critical event in the history of a system or service, leading to the evolution of new structures of interaction and new shared meanings. It will change relationships, displace existing activities and redistribute and transform resources (Hawe et al., 2009). Looked at in this way, a new intervention such as the volunteer programme needs to be explored in a different way.

Hawe et al (2009) suggest there are four main ways in which an intervention can be explored using systems level thinking:

- Uncovering how the intervention couples with the context - how far across the system the programme is evident, and how intensively it is integrated into routine practice.
- Tracking changes in relationships between providers, and between providers and service users.
- Focussing on the distribution and transformation of resources.
- Assessing activities displaced - what people in a community or clinic stop doing when they participate in a new intervention may be important (Hawe et al., 2009).

This approach was used to achieve the aim and answer the research questions for this PhD.

1.5. Aim and research questions

The aim of this study was to explore what volunteering is and how it works in a community-centred volunteer programme, through examining professionals', volunteers' and parents' accounts. More specifically, it aimed to answer questions on two major topics; volunteering and community-centred volunteer programmes. The research questions on volunteering were:

i. How is volunteering understood in the context of a community-centred public health programme? (Chapters two, three and seven)

ii. What elements influence volunteering in the context of a community-centred public health programme? (Chapters two, three and seven)

The research questions focussing on community-centred programmes were:

iii. How is a community-centred public health programme expected to influence change within a community? (Chapters three, four and six)

iv. In what ways does a community-centred public health programme influence stakeholders working within and participating in it? (Chapters three, six and seven)

By answering these questions, the thesis adds to the current knowledge base around community-centred public health approaches which involve volunteering, and the expectations and realities of them. It also contributes to the debates, notions and misconceptions around volunteering, particularly in the context of public health. The thesis also illustrates the factors which influence volunteering, both as a choice as well as an occupation. Lastly, the thesis adds to the knowledge base around the impact of such programmes; impact not in its traditional, positivist sense, but impact as understood and experienced by stakeholders in such a programme.

1.6. Structure of the thesis

The following two chapters form the literature review part of the study. Chapter Two focusses on volunteering, the understandings and notions as found in the literature and previous studies, its political underpinnings and its complexities. This will partly answer the two research questions on volunteering from the perspective of the literature (i and ii). Chapter Three presents the literature on community-centred approaches, their rationale, the evidence around them and the role of volunteering within them. It also considers the role of implementation of such approaches, the enablers and barriers and the impact that implementation can have on the approach and vice versa. This forms part of the answer to research questions ii, iii and iv, as it outlines the expectations around such approaches, the elements that may affect volunteering and the impact that such approaches can have on the community.

Chapter Four introduces the case study itself. The local context and the background to the volunteer programme are presented along with the wider intervention of which the programme was part. The volunteer programme is thoroughly described. Chapter Five illustrates the methodology and research methods that were used to achieve the study's aims and objectives.

Chapter Six forms the first chapter of the study's findings and answers research questions iii and iv. Having analysed a variety of qualitative data, it presents the expectations that underpinned the volunteer programme and the ways in which stakeholders within it expected it to influence change. The second part of the chapter provides insights into some of the ways in which the programme influenced change by presenting the reality of how the programme was implemented.

Chapter Seven forms the second chapter of the findings and provides answers to all research questions. It first considers stakeholders' notions of community, which inevitably shaped both

volunteering within the programme as well as expectations and realities of the programme. It then illustrates the tensions between professionals and volunteers, which were elements that influenced volunteering and the realities of the programme. Lastly, it presents the diversity of views on volunteers and their volunteering as well as the impact volunteering had on volunteers themselves.

Chapter Eight is the discussion chapter, where the literature review and the findings are interrogated against each other and conclusions are made. The strategic practice model that was developed based on the literature, research and the findings of this study is described and the strengths and limitations of the study are outlined. Chapter Nine draws the thesis to a close by focussing on the conclusions and original contributions of the thesis to the wider academic and research community and the study's implications for theory, research and practice.

2. Chapter Two: Notions and understandings of volunteering in the literature

This chapter focusses on the concept of volunteering as understood by and described in the wider literature. Firstly, a brief political background to volunteering is presented. Then, the layers of complexity of the phenomenon are outlined, along with the issues it presents in conceptualising, researching and understanding it. The dominant standpoints that have explored and theorised volunteering are discussed and the issues around theoretical understandings are interrogated. These theories are then put into the context of public health, leading to the third thesis chapter on community-centred approaches.

2.1. Politically contextualising volunteering

Volunteering in its broad sense is not a new concept. Despite its complexity it has been around for centuries, without drawing much attention from scholars, perhaps because it was seen as a routine part of civic life. However, more recently, volunteering has become the subject of much interest for academics and researchers, perhaps inevitably since it has simultaneously attracted interest from governments around the world. Volunteering has now become politicised and an overt part of governments' agendas and manifestos; governments of all political colours have advocated for its value (Brindle, 2015).

Experts in UK politics seem to attribute the first appearance of volunteering as a political idea to Margaret Thatcher and the Conservative party (Wheeler, 2005). By the time she came to power in 1979, the post-war welfare state of the UK was well established. Thatcher's vision was that communities should stop relying on provisions made by the state and instead rely on

the resources existing in their communities; the notions of philanthropy and self-reliance being central to this vision (Wheeler, 2005).

In her own words as spoken in 1981 she said:

> *"The willingness of men and women to give service is one of freedom's greatest safeguards. It ensures that caring remains free from political control. It leaves men and women independent enough to meet needs as they see them, and not only as the State provides."* (Thatcher, 1981)

Thatcher's rhetoric emphasised that volunteering should be encouraged so that people would be in control of their own communities, rather than the state. Thatcher was criticised extensively for these statements, not least because, when applied, her ideas meant that there were expectations on charities and voluntary organisations to provide services no longer funded by the state (Crowson, 2011). In addition, her critics noted that despite her desire to encourage volunteering, people's willingness to volunteer declined, turning Britain into an uncharitable country (Wheeler, 2005). When Tony Blair and New Labour came to power in 1997, he promised to restore communities. The political rhetoric was that society was broken following Thatcher's incumbency and something needed to change to ensure that communities stopped being individualistic and people started looking out for each other again (Wheeler, 2005). One of his infamous mottos at the time was that "we are all in this together" (Spencer, 2017). The need for responsible communities that valued reciprocity was highlighted as a means by which the restoration of a divided country would be achieved (Spencer, 2017). Part of the policy thinking background to these positions was formed as a result of the notions of social capital which gained ascendancy in the late 90s arising from Putnam's "Bowling Alone" (2000). The notions of social capital will be explored further in the next section.

It is apparent that the concept of volunteering thus appealed to politicians of both the Left and the Right, indeed suggesting that their ideologies were not that different. This was perhaps the result of the post war rise of the welfare State, the gradual discovery that demand for services was essentially limitless and could probably never be met through taxation, thus necessitating some form of rationing or further social insurance (Crowson, 2011). Therefore, volunteering was encouraged with an expectation that some services provided by the state could be replaced by the voluntary sector. Although somewhat new at the time, in recent times it is not uncommon for the voluntary sector to have the responsibility to provide previously state provided services. The politician who established this as way of providing services was Conservative former Prime Minister David Cameron and his idea of the "Big Society". Although presented as a new way of thinking about service provision, it essentially adopted Thatcher's ideas, repackaging them as part of the Big Society. This shows continuity in the political idea of community and volunteering which views them as salient and powerful and this cuts across political hues (Brindle, 2015).

As part of the 2010 general election, the Conservative Party publicised their policy "Big Society not Big Government" (Conservative Party, 2010a). Big Society was a new way of governing; not through big government but through empowering society, that is individuals, communities and ultimately the nation, to govern themselves, therefore creating the Big Society (Bulley & Sokhi-Bulley, 2014). Key notions in this policy were responsibility, empowerment and self-management. By empowering individuals, encouraging them to be active, responsible citizens who can manage themselves and their communities, society would take control back from big government, would restore itself and consequently become the Big Society (Bulley & Sokhi-Bulley, 2014). Bartels, Cozzi & Mantovan (2013) argued that Big Society was based on the idea that as government intervention increases in a community, volunteering activities decrease. Therefore, in accordance with Cameron's suggestion, by

decreasing governmental input, volunteering should increase and communities should become more resilient. However, the idea of Big Society has been criticised on a number of levels. It has been argued that following the launch of the Big Society, the promises made by the Coalition Government, namely to provide training opportunities for citizens and particularly young people; to finance charities and voluntary organisations so that they are able to recruit and manage volunteers and to give more power to councils (Cabinet Office, 2010), were not met (Scott, 2011). This led scholars to believe that there was a lack of commitment from the government to make Big Society work on a practical level; it was suggested that it was mainly a powerful rhetoric that was neither feasible nor practical to embed (BBC News, 2011).

Others have taken this thinking further, and on the same notion as previously mentioned for Thatcher's ideas. It was argued that the Big Society was merely a way to legitimise the reduction in funding for public services as well as the voluntary sector particularly following the financial crisis of 2008 (Kisby, 2010; Scott, 2011). In addition, the very idea that volunteering increases when support from the state decreases has also been disproved. Bartels, Cozzi & Mantovan (2013) conducted a study investigating the relationship between public spending and volunteering. They found the opposite of what the Big Society presumes, that is as state funding decreases, so does volunteering. However, as the authors noted, their conclusion is not in favour of Big Government and opposed to Big Society, it is rather an acknowledgement that funding from the state is crucial for volunteering to be sustainable (Bartels, Cozzi, & Mantovan, 2013). Although the Big Society was a widely debated policy, that had the potential to change the way the nation is governed, it did not live up to the Coalition Government's expectations. A report entitled: "Whose Society? The Final Big Society Audit" concluded that the Big Society had failed (Civil Exchange, 2015). Despite some Conservative MPs' attempts to assert that it had achieved successes, the last time the Big Society was mentioned publicly by Cameron was in 2013 and - shortly after - the term was removed from

the government's documentation, indicating that the failure of the Big Society was implicitly acknowledged (Civil Exchange, 2015).

Cameron's successor, Prime Minister Theresa May, has made no references to the Big Society. Instead, she has spoken about a "shared society", a society where the "brightest among the poor" are helped and where an active government works for them to ensure social justice in the post Brexit Britain (May, 2017). The progress of the "shared society" and its impact remain to be seen.

This introduction was meant to provide an overview of the political post war context in which volunteering has often been seen as a powerful mechanism for societal change. Its main aim was to introduce the debates around welfare versus free market politics, which extend to service provision. Inevitably, those debates have shaped, as it will be shown in the following chapters of the thesis, the findings of this study.

2.2. Defining volunteering and social capital

Volunteering has a strong presence in the literature, attracting interest from theorists and applied researchers offering multidisciplinary lenses to define, understand and explain it. However, as Hustinx, Cnaan and Handy (2010) observed, no single or integrated theory has been developed to encapsulate the variety of understandings of volunteering. Part of the reason for this is that defining what is or is not volunteering and what constitutes volunteer activity is challenging. Another problem is the very fact that volunteering has been studied through different disciplinary lenses and in isolation from other disciplines (Haski-Leventhal, 2009). Lastly, conflicting opinions exist in terms of what purpose a theory of volunteering would serve; would it be an explanation of why people volunteer, would it provide the context in which people volunteer and the structure needed for a volunteer programme or would it shed

light on issues around volunteering such as hidden ideologies and social injustice (Sutton & Staw, 1995)? This literature review presents in some detail the above contemporary notions and understandings of volunteering, starting with the problems with its definition.

Although most people have some understanding of what volunteering is, theorists and researchers have found themselves in a predicament with regards to agreeing to a definition. It is widely accepted that volunteering is a complex and according to some, a paradoxical act, and therefore defining it is challenging (Smith, 1981). From a purist perspective, volunteering is the devotion of an individual's time to benefit a cause or another individual (Wilson, 2000). However, this definition presents several problems, the most important of which is whether volunteers can or should benefit from their volunteering activities. According to some, volunteers' families and friends should not benefit in any way from volunteer activities (Carson, 1999). Therefore, babysitting for a relative or helping an elderly neighbour with their shopping would not be thought of as volunteer activity. Similarly, and following this line of thinking, volunteers should not receive any kind of reward for volunteering activities (Hustinx et al., 2010). Taking this argument, mothers who volunteer to support other mothers with breastfeeding and are reimbursed for their expenses are not volunteers but workers.

Another problem with the purist view on volunteering is the fact that there is no differentiation between volunteering and activism. For example, answering calls for Samaritans and organising Ku Klux Klan (KKK) meetings is equally viewed as volunteering, as long as neither volunteer receives a reward (Cnaan & Amrofell, 1994). Although, logically, both activities can be classed as volunteering, a definition ought to provide more clarity on the boundaries of volunteering. Indeed, Musick and Wilson (2008) provide a useful differentiation between volunteering and activism. They suggest that volunteering targets individuals whereas activism targets structures (Musick & Wilson, 2008). Therefore, although the Suffragettes were

volunteers, their activities targeted the structures of society; this differentiates them from a student who volunteers in nursing homes.

One of the most popular and widely accepted definitions appears to be Wilson's (2000). He defined volunteering as "any activity in which time is given freely to benefit another person, group or cause" (Wilson, 2000, pp. 215). He made a point that this, admittedly, vague definition does not prohibit volunteers from benefitting from their volunteer activities. However, this has been criticised as, similarly to the purist views mentioned above, being rather simplistic and not specific enough, allowing again for a number of activities to be regarded as volunteering (Ellis Paine, Hill, & Rochester, 2010). According to some scholars, the definition of volunteering needs to be more specific to conceptualise it better and thus advance understanding.

Many definitions of volunteering attempt to describe the phenomenon by what it is not; it is not paid employment, it is not a biological need, it is not coerced or forced labour (Hustinx et al., 2010). In addition, volunteering is not an activity that promotes hate (Neo-Nazi groups) despite the fact that people who partake in such activities may do it without any financial reimbursements. Whilst these limits advance understanding around volunteering to an extent, they still fail to define what volunteering is (Hustinx et al., 2010).

Cnaan and Amrofell (1994) and Cnaan, Handy, and Wadsworth (1996) attempted to provide a more nuanced definition for volunteering by performing content analysis of over 200 definitions in the literature. Their analysis showed that four main aspects to volunteering are commonly used to define it; free will, remuneration (or absence thereof), relation to beneficiaries and formal/informal volunteering. However, these aspects can be quite different depending on the definition; for example, free will can range from one's internal desire to volunteer, to volunteering as part of a university course, and remuneration can range from zero

to reimbursement of travel expenses. Therefore, and despite the helpful insights that scholars have provided into the definition of volunteering, it remains a problematic concept to define.

Similarly to these issues with defining volunteering, defining what is meant by social capital is also challenging. The two concepts have been linked in theory and research because reciprocity, co-operation and networking are integral to them. The term *social capital* has existed in literature for over a century but became a debated term in the 90s. Originally, social capital referred to the assets that form part of the everyday life of individuals at a societal level; the social bonds with other individuals, the goodwill to help the community and the sympathy towards other people (Hanifan, 1916). Social capital remained a relatively uncontested term until Robert Putnam published the infamous book "Bowling Alone: The Collapse and Revival of the American Community" in 2000. In his book, Putnam argued that as Americans became wealthier, their sense of community and reciprocity declined, the social bonds that once existed amongst communities were non-existent and therefore social capital was lost (Putnam, 2000). Putnam was criticised for these arguments as they were seen as vague and ambiguous but his book led scholars to explore social capital further in an attempt to understand it (Boneham and Sixsmith, 2003). Although its definition can vary depending on the disciplinarian lens through which it is explored, it generally is understood as the networks, activities or relations that are based on trust and bind people together within a community (Farr, 2004). Moreover, three types of social capital have been proposed; bonding, bridging and linking. Bonding social capital refers to the relationships that exist within an individual's immediate social environment (family, friends, peers etc.) and which provide a sense of belonging. Bridging social capital refers to relationships outside of an individual's immediate circle (work colleagues, distant friends etc.). Linking social capital refers to links with people outside of both immediate and intermediate circles; links with people at a wider societal level (Boeck, et al., 2009). These conceptual characteristics of social capital have been contested and, although many have seen

social capital as a largely positive term, some have warned of his potential negative consequences. Excessive trust in others can result in manipulation; people from outside the community can use the bonds and trust within them to manipulate communities towards decisions that are not necessarily beneficial for the community (Portes, 2014). In addition, a wealth of social capital can mean less self-reliance which can be problematic (Portes, 2014). This brief account of social capital aimed to show that although it is a term embedded in everyday discourse as a largely positive concept, it can be contested and debated. More importantly, one of the main arguments for volunteering and its benefits is that it increases social capital and vice versa. A study on volunteering, therefore, would be amiss if it accepted social capital in an unproblematic way.

Having delved into problems around defining volunteering and social capital, and acknowledging that one definition will not be able to cover all aspects of both terms, this study has adopted a broad definition which posits that volunteering is time devoted from a person to benefit others, regardless of personal psychological, social or minor economical gains. It is the researcher's belief that all volunteering activities result in some form of personal gain and the suggestion that this negates the activity altogether is somewhat unfair. Therefore, a person who decides freely to devote their time in order to support others in some way is a volunteer. Social capital is understood as the trust, social networks and relationships that already exist in a community and which can be developed further by volunteering. Defining what is and is not volunteering is only the first step towards understanding it. The second step is studying what theoretical lenses different disciplines offer in this exploration.

2.3. Theorising volunteering

Volunteering has attracted interest from disciplines in the Humanities (i.e. History and Philosophy), Social Sciences (i.e. Psychology, Economics, Sociology, Anthropology, Political Science) and more recently, Public Health. Each discipline studies volunteering in an attempt

to understand some of its facets, ranging from volunteers' motivations and volunteer recruitment and retention to social solidarity through volunteering and asset-based community development (Haski-Leventhal, 2009). In this attempt to advance understanding, it is important to consider what each discipline offers. Therefore, in the following sections the perspectives from economics, psychology, sociology and public health are presented. It is acknowledged that there are other disciplines that have studied volunteering; the disciplines that form part of this thesis were chosen because they offer the most influential and well researched perspectives that are also relevant to the findings of this study.

2.3.1. Economical perspectives

The underlying philosophy of economics, particularly as a form of explanation of human behaviour, is that individuals live their life and make decisions about it based on a cost-benefit analysis (Hustinx et al., 2010). The decision to marry is a prime example of where this theory has shown promising applications; people decide to get married when they believe that getting married will provide them with benefits (physical or psychological) that remaining single would not (Becker, 1976). Economists therefore, reject the notion of altruism; behaviours are calculated acts driven by the desire to benefit. Following this logic, volunteering would be the result of an individual's belief that, if they volunteer, they will receive benefits that would not be available to them otherwise.

There are three main theoretical models in economics that have been used extensively in volunteering research. The public goods model (Duncan, 1999) proposes that individuals offer their free time in order to ensure that the provision of public goods and services is maintained. This model accepts a notion of selflessness behind volunteers' actions but states that volunteers do receive some benefit. People who volunteer in hospitals for example, care about improving healthcare provision for others but, as more people volunteer, provision of healthcare improves and therefore society (including the volunteer) benefits (Emrich, 2016). The private

consumption model suggests that there is no altruistic motive behind volunteering; individuals volunteer because they get something in return. That may be the positive feeling from the act of volunteering itself, the relationships that are formed with other volunteers and the feeling of contributing to society (Emrich, 2016; Harbaugh, 1998). However, and although this model may be useful to explain why people donate money to charities, it fails to account for people who volunteer their time in emergencies such as fires. Volunteer firefighters could be facing life threatening situations; this model appears to do little to explain this behaviour, as it is fair to argue that the motives driving this behaviour would be more than merely a positive feeling. The last popular model in economics, as far as volunteering is concerned, is the investment model. This proposes that people see volunteering as an investment for future employment; the more they volunteer, the more skills they gain, and therefore are more competitive in the job market (Roy & Ziemek, 2000). Similarly to the private consumption model, the investment model can account for volunteering as part of an undergraduate degree but fails to provide explanations for volunteering in West Africa, helping people suffering from diseases.

In as much as the economic perspective on volunteering provides some insight into human behaviour and in this case volunteering, its shortcomings are apparent. The theoretical positioning that behaviour is a result of constant cost-benefit analyses offers a rather simplistic explanation for human behaviour and fails to account for numerous acts. With regards to volunteering, although it is not unreasonable to suggest that volunteers seek some benefit for their time and effort, the assertion that the benefit is the sole or principal motivation for the act is a narrow viewpoint. The psychological perspectives described below explore this argument further.

2.3.2. Psychological perspectives

Although volunteering has been researched by numerous areas in psychology, it is social and personality psychologists who have focused their efforts on understanding volunteer behaviour

(Hustinx et al., 2010). In contrast with economists, psychologists make no assertions about the motivation behind all volunteer behaviour; they acknowledge individual differences amongst people who perform prosocial behaviours. Thus, a large body of research in psychology of volunteering has focused on determining the personality traits of volunteers compared with non-volunteers (Murk & Stephan, 1991; Carlo, Okun, Knight, & de Guzman, 2005; Handy & Cnaan, 2007). However, and despite the fact that personality may play a part in how an individual acts, psychological studies have shown that there is more to human behaviour than traits, particularly around volunteering. Qualitative studies have found that personal connections to organisations or causes lead to people volunteering and perceived obligations to volunteer motivate people to continue volunteering (MacNeela, 2008). Moreover, Omoto and Snyder (2002) found five motivations to volunteer: values, community concern, esteem enhancement, understanding and personal development. Briefly, values refer to individuals' personal or humanitarian concerns and it includes religious beliefs. Community concern refers to the desire to help the community that an individual feels they belong to, whether geographically or ethnically defined. Esteem enhancement refers to volunteering as a way to increase self-esteem and understanding refers to volunteering as a way to understand other people, organisations or countries. Lastly, personal development refers to volunteering as a way of advancing oneself, whether this is in terms of career development or relationship building (Omoto & Snyder, 2002).

On a more theoretical level, and similarly to economists, psychologists have grappled with the notion of altruism and whether people are selfless or selfish beings. Dominant psychological theories suggest that people's ability to feel empathy and compassion for others encourages them to volunteer because they want to help. In an experiment conducted by Batson (1998) a person received (fake) electric shocks for failing a test while people watched. When the observers were asked to imagine the person's pain, those who felt empathy volunteered to take

the person's place and therefore receive electroshocks themselves, which the researcher interpreted as altruism (Batson, 1998). On the other hand, some psychologists dispute this interpretation by offering an alternative way of understanding these findings. According to them, seeing another person in pain makes an individual uncomfortable and unhappy and therefore the response to help is an attempt to make themselves feel better, as opposed to the other person (Maner et al., 2002). Following this logic, altruism does not exist; even in the purest form of selflessness, egoistical motives prompt an individual to act. However, research has shown that volunteers who feel an obligation to help others and therefore have higher altruistic values tend to volunteer for longer periods of time (Stukas, Hoye, Nicholson, Brown, & Aisbett, 2016). An explanation for this would be that self-interest motives are dependent on circumstances (employed or unemployed) whereas altruistic values tend to remain constant (Stukas et al., 2016). Nevertheless, theorists have argued against this somewhat simplistic categorisation of motives, noting that the reasons for volunteering are more complicated and deeply rooted and thus not necessarily recognised by volunteers (Hustinx et al., 2010).

Whilst this debate on a philosophical level is interesting, psychologists have admitted that the question of whether altruism exists may bear no real significance in understanding why people volunteer. As Clary and Snyder (1999) point out, it would be rather difficult to differentiate between altruistic or egoistical motives as they can be intertwined and one does not preclude the other (Clary & Snyder, 1999). People can indeed desire to help others in need whilst simultaneously developing themselves.

2.3.3. Sociological perspectives

Similarly to economists and psychologists, sociologists have debated the notion of altruism and its relation to volunteering. In line with the psychological perspective, there are two main schools of thought in sociology that are useful to consider. The first presumes that people make rational decisions after weighing the costs and benefits (similar to the thinking of economists).

The second assumes that people are far more complex and they make decisions based on motives, values and beliefs they hold without necessarily being aware of them (Wilson, 2012; Wilson, 2000).

A notable theory from the former school of thought that offers some explanation for volunteering is the theory of human capital. It posits that a person's education, training, knowledge, skills, family values are all forms of capital; human capital. It is based on these that a person is able to weigh the costs and benefits of a behaviour and decide whether to engage with it or not (Becker, 2008). The theory of human capital is supported by research evidence, as higher levels of education have been consistently found to be a predictor of volunteering (Son & Wilson, 2017). However, some differences have been observed, whereby political volunteering has been linked with higher educational levels and informal community volunteering with lower educational levels (Omoto & Snyder, 1993). Wilson and Musick (1997) offer an explanation for this based on theories of capital. In order to volunteer, they theorise, three forms of capital are necessary: human capital (education, skills and knowledge), social capital (networks and relationships in a society) and cultural capital (high social standing in a society) (Wilson & Musick, 1997). This is easily understood in the context of needs, a person who has wealth (financial, psychological or social) sufficient to cover their own needs, is more likely to donate funds, time and effort to helping others. However, this is in contrast with theories on motivations of volunteers discussed above; if the notion that volunteers have a surplus of human, social and cultural capital is true, then their motives for volunteering would be different. Taking into account the family values aspect of the theory, studies have found that children are more likely to volunteer if their parents are also volunteers (Caputo, 2009). This suggests that indeed, family values influence the decision to volunteer. However, it is unclear whether this is part of a conscious and calculated decision or a decision based on values of which an individual may be unaware. Although human capital theory provides some

determinants which can predict volunteering, it fails to describe why or how these determinants work in order to produce an act (Wilson, 2000). In other words, even if it is accepted that education levels and family values can predict volunteering, it is unknown, based on this theory, when, how and why an individual will decide to volunteer.

Another prominent sociological theory in the same school of thought is the social exchange theory. It proposes that all relationships that people form are based on exchanges; a person will volunteer when they believe that they will receive something in exchange for their time and effort (Cook & Emerson, 1987). Interestingly, Gee (2011) found that parents tend to volunteer in their child(ren)'s school, as they see it as beneficial for their children; even if they are not getting something back themselves, the expectation that their children will receive the benefit of volunteering is present (Gee, 2011). Others have shown that some people volunteer because they like to be seen as doing work for the greater good or because they want to make friends (Carpenter & Myers, 2010; Prouteau & Wolff, 2008). Following the logic of the social exchange theory therefore, it would seem fair to argue that when volunteers receive incentives for their volunteering (i.e. travel expenses) then they would contribute more time. However, research has shown that volunteers with strong intrinsic motivations contribute less time when they receive financial incentives (Fiorillo, 2011). In a general criticism of the theory, and while studies support the notion that volunteers in many cases expect some benefit for their volunteering, be it monetary, social or psychological, it can be suggested that this is not the prime reason for their volunteering. Hart, Atkins and Ford (1998) showed that identity is important; if people identify as helpful to others, they will help without expecting to be praised (Hart, Atkins, & Ford, 1998). Therefore, conceptualising volunteering in terms of merely an exchange would be amiss.

With regards to the second school of thought in sociology, it is rooted in classic sociological concepts such as solidarity and social ties in society. From this standpoint, volunteering is an

act that develops social bonds unlike any others in a community; through its altruistic and prosocial nature, it can enhance integration and community spirit. In a study after the 9/11 attacks in the USA, Beyerlein & Sikkink (2008) found that volunteers felt a personal responsibility for helping others (Beyerlein & Sikkink, 2008). In fact, research has shown that solidarity appears to be a motivator for volunteering, particularly for political organisations and after natural disasters or crises (Wilson, 2012). That said, the feeling of solidarity has been found to be dependent on the size of the community or organisation; the smaller the community, the more responsible people feel and therefore the more likely they are to volunteer (Ward & Mckillop, 2011).

It is fair to argue that in as much as the sociological perspectives on volunteering provide a wider community-wide context within which it can and ought to be studied, as far as the theoretical basis for it is concerned, there is little agreement. This, along with theoretical disagreements presented from other disciplines adds to the aforementioned problem of the definition of volunteering, thus making its study rather complicated.

Thinking more broadly, taking into account the perspectives outlined so far, and based on my personal epistemological views which will be outlined further in the methodology chapter of the thesis (Chapter 5), the differing theoretical perspectives have important implications for the study of volunteering. From a personal point of view, I understand volunteering as a deeply personal decision as it involves the devotion of time and effort, and therefore the reasons and motivations will be dependent on the individual. Trying to establish whether volunteering is the result of cost-benefit analyses, a combination of personality traits or a form of social exchange suggests that there is one truth about volunteering and one discipline can find that truth. I reject this notion as some people will volunteer with pure altruistic motivations whereas others will volunteer as part of a university course because it will help them secure employment opportunities.

2.3.4. Public health perspectives

The previous sections have provided an understanding of the complexity of volunteering as well as the diversity of theories around it. Considering that the starting point for this PhD was a volunteer programme implemented as part of a public health initiative, it is imperative to position the above learning in the context of public health.

The public health perspective understands volunteering as a way to engage with communities, empower individuals within them and help them take control of their health and wellbeing as well as the community in general (Jenkinson, et al., 2013). This perspective moves away from the idea that communities are passive recipients of interventions that aim to improve their health and sees them as actors of change. Through these lenses, volunteering offers an opportunity to educate and empower communities, with the ultimate purpose of having confident people who are able to assume a public health role within those communities (Israel, Schulz, Parker, & Becker, 1998; South et al., 2012). It recognises that people and communities should be viewed as having assets rather than deficits. Using smoking as an example, instead of blaming smokers for their addiction, public health should celebrate those who have quit and provide them with the knowledge and ability to influence other smokers.

Public health sees volunteering as a community led intervention, which can be far more influential and effective in improving health and wellbeing compared to the previously used model of professional led interventions. Contrary to some beliefs, volunteering in public health is not seen as a way of creating a semi-professional workforce that can replace professionals and services. It is rather a way to improve citizenship and civic involvement (similarly to some of the theories above) and ultimately democracy from a public health (but also a wider societal and political) point of view (South et al., 2012). The public health perspectives will be further explored in the next chapter of the literature review.

The theoretical perspectives presented in this section show the different notions and understandings of volunteering in the literature, most of which centre around the debate of altruism versus egoism. This debate is important to be considered in any study of volunteering as it can have implications for volunteering programmes, volunteer recruitment and retention. That is, whether people generally believe that volunteering is altruistic or egotistical will influence their views on it and their attitudes towards volunteers. This could in turn influence a volunteer programme. However, it is equally vital to conceptualise volunteering as a process.

2.4. Volunteering as a process

Volunteering, similarly to any other form of work, is not a straightforward process; a new employee will require time to settle into an organisation, understand (or misunderstand) its values and vision and accept or reject its culture. Thus, volunteering can and should be investigated as a similar process, taking into account not only why people volunteer and what motivates them, but also how they volunteer and how they change over time (Hustinx et al., 2010). To this end, several researchers have developed theories on the ecology of volunteering, resulting in micro, meso and macro system theories (Kulik, 2007). Micro-system theories narrate how volunteering is a group activity, and being part of a group of volunteers has benefits for volunteers and their experiences (Haski-Leventhal & Cnaan, 2009). Meso-system theories focus on the organisational processes needed to manage volunteers. Due to the non-paid nature of volunteering and the absence of contractual obligations, managing volunteers has to differ from the management of paid members of staff (Brudney & Meijs, 2009). Meso-system theories therefore attempt to describe what processes an organisation ought to employ in order to manage volunteers effectively.

Lastly, macro-system theories are relatively underdeveloped, partly due to the difficulties that volunteering presents as a concept which have been outlined in this section. Macro-system theories tend to investigate volunteering rates and differences in volunteering by country

(Hustinx et al., 2010). Indeed, differences in the rates of volunteering have been observed amongst countries which can be attributed to historical and cultural values that each country possesses; for example political stability, religion and economic development have been found to be relevant to volunteering rates (Ruiter & De Graaf, 2006).

In addition to these theories, macro-system theorists have also tried to explore volunteering within the ever-changing societal context in which it exists. Studies have found that volunteering is not immune to the forces of modernisation and individualism that have flourished in recent decades. Volunteering itself has shifted from a group activity primarily motivated by a sense of community and with the collective good in mind, to a more self-oriented and self-interest based volunteering which shows little organisational attachment compared to previous decades (Beck & Beck-Gernsheim, 2009; Hustinx & Lammertyn, 2003). However, and although it may be the case that individualism is prominent, recent studies show that particularly after the economic crisis of 2008 and the austerity measures being introduced in the western world, volunteering has increased (Hustinx et al., 2010). This can be interpreted as a renewed sense of community and collectivism for people.

2.5. Criticisms of volunteering

Although the majority of theories in the study of volunteering tend to accept the notion that volunteering is a good and noble activity for people to be involved in, there are a number of theories which offer critical perspectives and question this assumption that ought to be explored. Studies have consistently shown that people of higher economic and social status tend to volunteer more and tend to hold more prestigious roles in their volunteering (Smith, 1994). Although this is not by any means exclusive, and people from lower economic and social backgrounds also volunteer, it is indeed a phenomenon that has been observed in numerous studies (Wilson, 2000). An explanation for this phenomenon has been provided by researchers who found that organisations tend to recruit volunteers of certain social and

economic status. Miller et al. (2002) found that volunteer organisations tend to exclude people with disabilities and Morrow-Howell et al. (2003) showed that volunteering opportunities were available to people of higher economic and social status (Miller, Schleien, Rider, & Hall, 2002; Morrow-Howell, Hinterlong, Rozario, & Tang, 2003). Therefore, it is possible that education, skills and social standing are not determinants of volunteering from the volunteers' perspective but are, rather, the consequence of selection criteria posed by organisations. Conversely, many organisations caring for disabled people find that volunteering provides the only way for their charges to gain work experience, as someone with learning difficulties, for instance, might find it impossible to compete in the 'real' job market (James, South, Southby, Buck and Tree, 2017).

Many have argued that volunteering can decrease social inequalities by supporting and empowering vulnerable people in the society, enhancing social inclusion and integration and giving voice to often marginalised groups (Miller et al., 2002). However, the studies above show that people of certain economic and social status are preferred volunteers. This can serve to marginalise vulnerable people even further, as volunteering becomes an activity for those with ample means and excludes the ones without. Thus, volunteering can promote social exclusion and inequality.

In addition, researchers have emphasised the tendency to overlook negative consequences on volunteers and only focus on the positive effects of such activity. People who volunteer in hospices or with victims of sexual violence tend to experience burnout just as paid workers do (Kulik, 2007). Partly because volunteering is an act of free will and because volunteers are not bound by contractual obligations, research has overlooked the difficulties that they might face during their volunteering, leading some to believe that beside burnout, other negative consequences (mental health issues for example) need further investigation (Hustinx et al., 2010).

Another critical point in volunteering research is the notion that volunteering has an impact on societies in general. Indeed, a lot of previous research has accepted that volunteering improves and empowers communities without however, having evidence for the assumption. Eliasoph (1998) disputed this by claiming the assumption that volunteering strengthens social ties and improves social capital is optimistic. She found that many volunteers prefer to engage in service tasks and avoid involvement in political activism and therefore are only concerned with volunteering on a micro-system level without attempting to tackle the bigger societal and political issues. She concluded that, contrary to the claim that volunteering is a democratic activity that can enhance civic involvement and participation, it is in fact an activity which can be used to absolve volunteers from their political responsibility (Eliasoph, 1998). Although the fact that people do not engage in macro level political activity in no way invalidates the value to the society or the individual of micro level activity, in an idealistic way of thinking, Eliasoph felt that people should use their energy and willingness to volunteer to influence change at a macro level rather than their own community.

Lastly, and perhaps one of the most apparent critical points on volunteering, is its use by governments as part of the neoliberal agenda. Volunteering has been praised by governments, particularly in the UK but also abroad, as an activity which can empower communities and therefore minimise their need for welfare provision (Musick & Wilson, 2008). However, many have felt that this is merely a way to legitimise government's reducing or cutting funding for public services as well as the voluntary sector, particularly following the financial crisis of 2008 after which austerity measures were adopted and funding for service provision became scarce (Kisby, 2010; Scott, 2011). Nevertheless, and if these views are seen as particularly cynical, there is another danger with government-encouraged volunteering. That is, if volunteering is regulated by the government then political or activist volunteering will cease to

exist and, in turn, safe, non-political volunteering will dominate (Hustinx et al., 2010; Musick & Wilson, 2008).

2.6. Summary

The purpose of this chapter was threefold; to provide the political context of volunteering, to outline the complexities surrounding its definition and to explore the notions and understandings around it from different academic disciplines.

With regards to the political context, volunteering has been widely advocated and encouraged by governments in the post war UK indicating that it cuts across political ideologies. Arguments have been made as to whether this is because of the conservative desire to reduce expensive service provision or because of a genuine belief that individuals should contribute more to their communities. Regardless of the reasons however, volunteering is a legitimate approach to the nation's welfare and therefore it requires thorough and fair exploration.

To this end, several disciplines have examined volunteerism. Economics, psychology and sociology study volunteering for different reasons (volunteer recruitment and attrition, volunteers' motivations and personality traits or social integration and solidarity through volunteering) and offer different explanations for the phenomenon. However, in terms of the underpinning philosophies that each discipline offers, it appears that there is only one major debate common to all: **altruism versus egoism**. It was particularly interesting, from a researcher's point of view, to study and understand these dominant theories and explanations of volunteering as they provided the context in which volunteering is most commonly explored. This context, coupled with the findings of this study have implications for both theory and practice which are presented and discussed in the discussion section (Chapter 8). Nevertheless, and whilst the academic debate is interesting to continue, theorising on a single disciplinary level might not be useful for the ongoing research on volunteering.

This overview of the theories and evidence around volunteering help to inform the current understandings of it. However, these understandings need to be situated in the context of public health for two reasons; firstly, because volunteer programmes are being used as public health interventions and secondly, because a public health initiative was the context for this thesis.

The public health approach therefore is not concerned with explaining volunteering on a theoretical level; it is concerned with its ability to change and influence communities, to tackle the wider determinants of health (social and economic disadvantages) and ultimately to improve public health. In order to achieve that, public health theorists have proposed using community-centred approaches, a topic that will be further explored in the following chapter.

3. Chapter Three: Community-centred Approaches in Public Health

This chapter focusses on community-centred approaches to public health. Firstly, important definitions are discussed, followed by an overview of the relationship between community and health. The community-centred approaches commonly used in public health are presented. The chapter then focusses on volunteering in the context of community-centred approaches as well as the relationships between volunteers and professionals within such approaches. The evidence for such approaches is appraised and community-centred approaches are put into the context of complex interventions. A summary with the main points closes the chapter.

3.1. Important definitions

Defining some of the key terms in community-centred approaches is vital, particularly given their subjectivity. Community, empowerment, assets and development are central to such approaches and are commonly used both in everyday discourse and amongst academic circles. As such, they can have multiple meanings depending on the context in which they are used. Given the focus of this thesis on community and volunteering, and considering that the previous chapter examined the intricacies of volunteering, the definitions of terms relevant to community-centred approaches are presented first.

3.1.1. Community

The first sociological definitions of the term described communities as geographical areas or groups of people living in a specific place. Later explanations added more layers to the notion of community and also understood it as a value, which encapsulates elements such as solidarity and trust rather than mere geographical places (Smith, 2001). Frazer (1999) argues that these definitions are intertwined in that different types of communities share different aspects of relationships and bonds (Frazer, 1999).

Communities therefore can be defined by the place which they occupy e.g. residents of a certain town, village or neighbourhood are part of the local community. It can be defined by shared interest, whereby individuals share common characteristics aside from the place in which they live; the Christian community for example shares religious faith but not necessarily the same geography. Lastly, communities can be defined by the shared identities of their members; immigrant communities that settle into a new country for example (Smith, 2001). Given the advent of new technologies which have linked people with shared interests and identities above and beyond geographical places, the notions of community are continuously expanding and changing. With these definitions in mind, it is apparent that people can belong to different communities simultaneously.

Another important dimension of community was argued by Cohen (1985), who suggested that communities are much more than groups of people bound by their geography, interests or identities. Communities are symbols that people use to create meaning, develop a sense of belonging and, more importantly for Cohen, create boundaries that differentiate their communities from others. He made the point that exploring what meaning people give to the term community is essential. He noted that 'community' expresses both similarity and difference. It was this concept of difference that encouraged him to focus on the notion of community boundaries. Boundaries can be physical (mountains, seas etc.), administrative (borders of a country) linguistic and racial but can also be less tangible e.g. ideas or beliefs (Cohen, 1985). This argument adds a layer of complexity around the notion of community; although in everyday discourse the term "community" has primarily positive connotations, Cohen's ideas on boundaries and differences amongst communities add a potentially negative layer to the term. This explains certain closed communities which can have an "us" versus "them" mentality.

One definition that accounts for all the differences and similarities that communities might share is the definition from the National Institute for Health and Care Excellence (NICE). According to that definition "a community is a group of people who have common characteristics or interests. Communities can be defined by: geographical location, race, ethnicity, age, occupation, a shared interest or affinity (such as religion and faith) or other common bonds, such as health need or disadvantage." (NICE, 2017).

This discussion around the definition of community is particularly important for the context of this research, given that the volunteer programme under exploration was community-centred. Acknowledging that the term community can have different meanings for different people therefore is pivotal.

3.1.2. Community development

Similarly to the problems with defining the term "community", defining what is meant by "community development" can be challenging (Green and Haines, 2015). The roots of community development as a concept can be found in economics, sociology, social work, planning and political science. Indeed, all these fields are relevant to community development; from economic growth and employment opportunities to service provision and support, these disciplines offer useful lens through which community development can be studied (Arensberg, 2017). Due to the plethora of disciplines theorising on community development, it has often been more simply defined through its intended outcomes. Some of these outcomes can be addressing poverty and unemployment, promoting democracy and civic participation, tackling health and economic inequalities and building community cohesion (Rubin, Rubin, and Doig, 1992). Community development, it has been argued, involves structural change, particularly around distribution of resources and how these resources are used to the community's benefit (Arensberg, 2017).

Community development is normally informed by practice rather than theory and some debate exists as to whether community development is a process or rather the intended outcome (Green and Haines, 2015). Community development and its relationship to health and wellbeing have been extensively studied and theorised. Traditionally, and particularly from a public health standpoint, communities have been framed in terms of their deficits, health needs and problematic behaviours resulting in public health needs-based community development approaches (top-down) being developed (Hopkins and Rippon, 2015). In recognition that such needs-based approaches to community development were problematic and unsustainable, the focus shifted to asset-based community development approaches (bottom-up) (Kretzmann & McKnight, 1993). Asset-based community development approaches in public health are rooted in the concept of salutogenesis originally developed by Aaron Antonovsky (1979) which posits that focussing on factors (assets) that can facilitate health and wellbeing is a more effective approach compared to the traditional approaches which emphasise risks, disease and ill health (Lindstrom and Eriksson, 2005). Highlighting the problems within a community can result in a self-fulfilling prophesy; if their deficits are highlighted to them, people may start accepting that the community is problematic, feel powerless and unable to change it (Mathie & Cunningham, 2003). This can lead to mistrust amongst members of the community and therefore relationships and networks can deteriorate; people start relying on service provision rather than on each other. Recognising community assets and appreciating their potential impact for both health and community development is therefore vital.

3.1.3. Community assets

An asset has been defined as any form of cultural, human, natural, financial, political, social and built resources and capital that exist within a community (Wilcox & Knapp, 2000; Burkett, 2011). By identifying or mapping these assets, individuals can be empowered and can work

towards improving community health and wellbeing. Many scholars have asserted that these different forms of capital are vital in a community and when they are mobilised, they can bring about change from within (Emery & Flora, 2006). Community assets relevant to health can be internal, such as the relationships, friendships and networks that exist between members (i.e. social capital), the knowledge, skills and capacity of members to influence change, the local voluntary organisations and agencies supporting members, the physical space and environment of a community. They can also be external; funding for activities or interventions that is secured by organisations from all sectors is an important asset for health and wellbeing (PHE and NHS England, 2015; Denley, 2017). When such assets, which differ between communities, are identified and mobilised, they can build and enhance capacity by educating and empowering people within them (Mathie & Cunningham, 2003). Therefore, communities are able to take control and facilitate change based on their needs and desires. Ultimately, work is being conducted **with** communities rather than **on** them, which can lead to community development and improved health and wellbeing (Hopkins and Rippon, 2015).

3.1.4. Community empowerment and capacity building

Empowerment is a term that is used frequently in everyday discourse, sometimes interchangeably with terms such as confidence and self-esteem. In community-centred approaches however, the term empowerment is synonymous with participation and civic engagement (PHE and NHS England, 2015). At an individual level, empowerment means having control over one's life, being able to make decisions about health and wellbeing and having the power to influence change (Laverack, 2006). At a collective level, community empowerment is the work that is being conducted by communities in order to take control of their community and promote change within it. Empowerment of communities should not be interpreted as empowerment of each individual within a community necessarily, but rather as

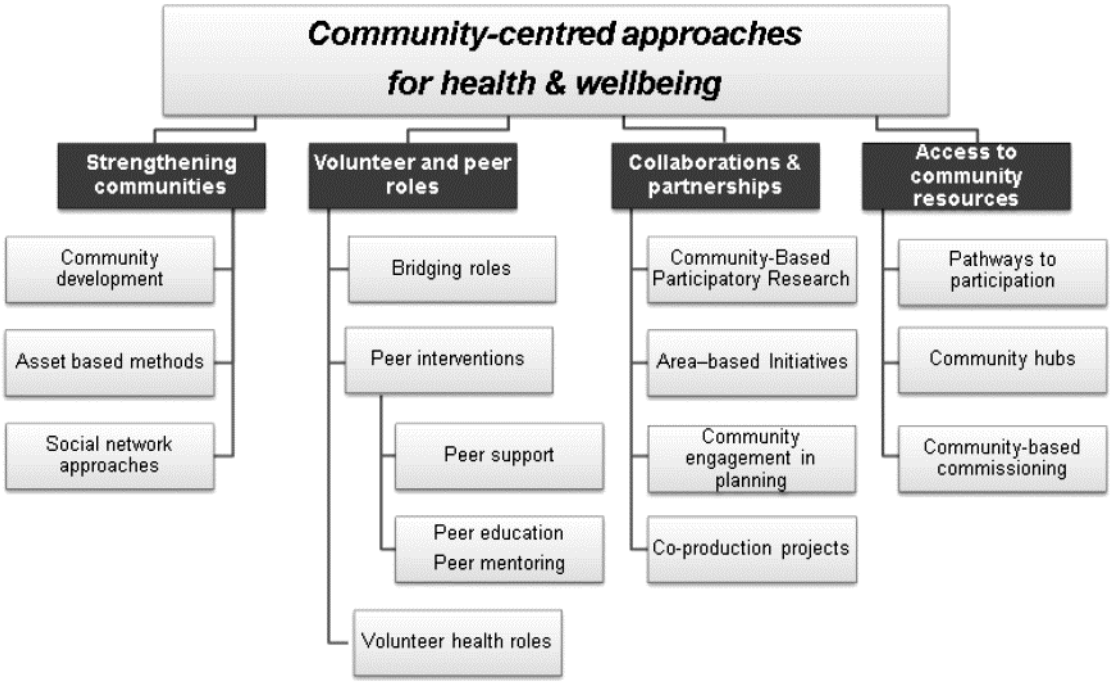
a collective process by which individuals work together to regain power and take control over their community (Aigner, Raymond, & Smidt, 2002). Community empowerment however, is not a standalone process; a community may be able to take control over its resources and assets but may be unaware how to spend them on in order to improve health and wellbeing. A community, therefore, needs to be able to understand, identify and assess local issues that affect it the most, be able to prioritise these issues and tackle them accordingly. This is the definition of community capacity (Liberato, Brimblecombe, Ritchie, Ferguson and Coveney, 2011; Phillips and Pittman, 2014). Capacity building is the process which ensures that individuals who participate in community related activities are able to identify and assess issues, have a say in what happens to their community and make decisions about the distribution of resources (Bhattacharyya, 2004). Both community empowerment and capacity building are central to community approaches to health.

3.2. Community-centred approaches in public health

Community-centred approaches in public health broadly aim to: identify and mobilise community assets; promote equity and equality in health within communities; advocate for health and wellbeing in community settings; empower communities and facilitate public involvement in community health and wellbeing decisions and services (South, et al., 2017). Contrary to community-based approaches which tend to target certain populations to which professional-led interventions are delivered in a community setting, community-centred approaches focus on empowering communities, building community capacity and cohesion and promoting equity amongst community members (PHE and NHS England, 2015). Under the umbrella of community-centred approaches, various types of interventions exist that are commonly used in the UK. South, et al (2017) following a collaboration with PHE and NHS England for the project "Working with communities – empowerment evidence and learning",

which began in 2014, undertook a scoping systematic review of reviews to identify and categorise commonly used community-centred approaches. After analysing 168 papers, four categories (styles) of community-centred approaches were identified, namely: those that aim to strengthen communities; those that facilitate and enhance volunteer/peer roles; those that utilise collaboration and partnerships between communities and professionals; and those that improve access to community resources (South, et al., 2017). Figure 3.1 below presents the categories of community-centred approaches and their sub-categories as devised by South, et al. (2017).

Figure 3.1.: The family of community-centred approaches for health and wellbeing (source: PHE and NHS England 2015: 17).



As the Figure shows, each community-centred approach can involve a variety of methods that are generally used to achieve the intended aim(s) with common denominator the set of relationships and assets within a community (PHE and NHS England, 2015). Indeed all methods focus on the involvement and mobilisation of existing assets, particularly in terms of social capital, although the way in which these assets are utilised or the outcomes they are trying to achieve can differ. Approaches which aim to strengthen communities use asset-based community (ABCD) and social network approaches primarily in order to build capacity within a community so that community members can take control over their health and wellbeing (Kretzmann and McKnight, 1993; Foot and Hopkins, 2010; South et al, 2017). Approaches which aim to facilitate volunteer and peer roles, use people from the community (local assets). They enhance people's capabilities and knowledge around health and wellbeing issues with the ultimate purpose for the volunteers/peers to support the community by providing advice, signposting to services or organising health and wellbeing events (PHE and NHS England, 2015; Rippon and Hopkins, 2015; South, et al., 2017). Community-centred approaches which utilise collaborations and partnerships use participatory community methods to engage and involve communities in the design, implementation and delivery of services. Lastly, approaches which promote access to community resources, use existing assets within the third sector in order to connect community members with resources such as social activities (South, et al., 2017).

Although the community-centred approaches as presented here appear fairly distinct and with different aims, objectives and methods, in reality community approaches can adopt several methods and can aim to achieve a number of outcomes that overlap between the different groups. This presentation, however, is a useful way of understanding the variety of approaches in existence.

However, community-centred approaches have been criticised for a number of reasons. Firstly, it has been suggested that community-centred approaches sometimes assume homogeneity within a community and thus fail to take into account the disparities that exist within members of a community (Peterman, 2000). For example, it has been argued that white male members of a community are easier to empower and mobilise compared to women or people of a lower socio-economic background. It can be therefore argued that the existing power imbalances within a community are not considered to the extent they should be within community-centred approaches (Peterman, 2000). Even if these power balances are taken into consideration, it is often unclear what effect approaches to address imbalances have and whether they make any difference. Empirical evidence has shown that the shift in power from professionals working within such approaches to individuals from the community is not always observed as the dominant, top-down model prevents professionals from relinquishing control (Malterud, 2010; Farr, 2018). Both Malterud (2010) and Farr (2018) argue that currently, although co-production and community involvement is being encouraged and facilitated in a number of different initiatives, the decision making and therefore the power still lies with professionals; they are the experts, not the community. Therefore, although communities may be consulted about certain needs and desires, it is professionals who hold the power to address them. This, instead of tackling inequalities it further exacerbates them.

MacLeod and Emejulu's (2014) work adds a further layer of criticism of community centred approaches as they propose that such approaches can distract people from studying and tackling structural inequalities by focussing on the positive. In a somewhat radical way of thinking, if the deficits or problems within a community are ignored by focussing on its assets and strengths, then the structural inequalities that may affect it (such as access to healthcare, education, employment etc.) may go unnoticed and unchallenged which again, exacerbates inequalities. They also argue that community centred programmes may favour cohesive

communities but marginalise "hard to reach" or less cohesive, resistant communities. Cohesive communities, they suggest, are aware of their needs and desires and therefore, given resources to aid their development, they are in a better position to spend them compared to newly formed or disadvantaged communities which may be unaware of their assets, issues or the need for development and change (MacLeod and Emejulu, 2014).

Indeed, another weakness of community-centred approaches lies in their inability to describe how to implement them in environments where the community is resistant (Mathie & Cunningham, 2003). South, et al.'s (2017) work relies on the assumption that such approaches and their intended outcomes are recognised and desired by communities. This, however, is not necessarily true. Notwithstanding the critiques however, community-centred approaches remain popular in public health. Due to the fact that the focus of this PhD was on a community-centred approach that primarily used volunteer/peer roles, the next section focuses on volunteering within community-centred approaches, provides some critiques and looks at the current evidence around the effectiveness of such approaches.

3.3. Volunteering in community-centred approaches

Volunteering is often an integral part of community-centred approaches. When empowering communities and building capacity within them, volunteers from the community can play an important role both in terms of taking control and making decisions (volunteers as leaders) but also in terms of supporting their community by providing help and support to vulnerable members (volunteers as helpers) (Benenson & Stagg, 2016). In the former role, volunteers work together to decide what their community needs and work with organisations and service providers to ensure that those needs are addressed. In the latter role, they work with individuals from the community to support them with their imminent needs (such as breastfeeding) having previous experience or knowledge. Interestingly, Benenson and Stagg (2016) discuss the roles

of volunteers as very much directed from the volunteers themselves and do not see the provision of training for volunteers as necessary; volunteers have knowledge that is important to the community without training provision.

Likewise, volunteering within community-centred approaches has several benefits for volunteers, some of which have been discussed in Chapter 2, but are explored further here. Whereas theories of capital presented previously see volunteers as possessing it and, through volunteering, transferring it to the community, Benenson and Stagg (2016) focus on the capital that volunteers can gain through volunteering. Human, social, cultural and political capitals are built during the volunteering process particularly for volunteers from a disadvantaged socio-economic background (Benenson & Stagg, 2016). Volunteers can develop their personal skills and knowledge, gain experience from working alongside professionals and explore different career paths (human capital). Through working in their communities, they can build new social networks and strengthen their ties to the community (social capital). This is particularly important for volunteers who are new to a community, as it develops their sense of belonging. Strongly associated with this is the construction of new identities for the community by sharing cultural knowledge, traditions and beliefs which can enrich the community (cultural capital). Lastly, by taking part in community development, volunteers develop capabilities around civic life and political involvement (political capital). Thus, volunteering should not be seen as merely a tool within community-centred approaches to achieve systems change and integrate services but also as an important mechanism for community and personal development of service users. By appreciating volunteers' assets and building on them, community development becomes possible.

One of the most disadvantaged groups of people in terms of their socio-economic background, ties with the community, reduced sense of belonging and reduced capability around civic life

and political involvement is asylum seekers and refugees. Using Benenson and Stagg's theory, asylum seekers and refugees are (or should be) prime candidates for volunteer activities in their host countries given the fairly obvious benefits for them but also taking into account the wealth of experiences, cultural knowledge, traditions and beliefs that can enrich their new communities. Some research exists which supports this notion. Hussein, Manthorpe and Stevens (2011) conducted a qualitative study with asylum seekers and refugees and found that they are willing and eager to enter the UK labour market; particularly the social care market. Their wealth of personal experiences as well as their adaptability to change and problem solving abilities were cited as vital to the social care industry. However, this study focussed on paid employment rather than volunteering.

Generally, there is a lack of evidence around the benefits of volunteering for asylum seekers and refugees and the potential that they have to develop and improve communities. The majority of studies around asylum seekers currently is around the experiences of volunteers who support them (Jones and Williamson, 2014; Hebbani, Khawaja and Famularo, 2016; Fleischmann, and Steinhilper, 2017) or their experiences of living in a host country (O'Reilly, 2018). Perhaps due to the fact that asylum seekers are seen as a vulnerable group in need of help from the state, some studies exist around interventions that could enable them integrate into a community through sport; predominantly football (Hartley, Fleay, Tye, 2017; Stone, 2018; McDonald, Spaaij, Dukic, 2019). However, there is a lack of studies that explore the experiences of asylum seekers who volunteer and the potential that they have in improving communities. This is a gap in the current literature that can be filled by some of the findings of this study.

3.4. Volunteer and professional relationships

Volunteering within community-centred approaches presents several challenges, the most important of which is professionals' resistance to working with volunteers (Netting, Nelson, Borders, & Huber, 2004). Previous research has observed this issue consistently and factors have been identified that are related to this resistance. Volunteers' age and credentials can play an important role in relation to their acceptance from professionals; young people may be seen as too inexperienced, but older volunteers with expertise in specific areas can be perceived as threats, due to their ability to assume professionals' roles (Brudney, 1990). In addition, paid staff may see volunteers as difficult to manage, due to the absence of leverage (formal contract) or due to the time they require to be trained in working alongside them. Lastly, it is common for professionals to resist working with volunteers because of their status. Being a professional comes with a certain status and standing within an organisation and volunteers can be perceived as pseudo-employees with a lower status and standing (Brudney & Meijs, 2009).

Bochove, Tonkens, Verplanke and Roggeveen (2016) proposed that some of the resistance from staff towards volunteers is a result of ill-defined boundaries between them. They observed that the expectations towards volunteers were conflicting in that they were expected to be professional and knowledgeable in order to perform their tasks whilst simultaneously maintaining a 'down to earth', 'warm' attitude which contradicts the 'impersonal' attitude of professionals (Bochove, Tonkens, Verplanke, & Roggeveen, 2016). These expectations can lead to uncertainty around the roles that volunteers and professionals are supposed to fulfil which can result in tensions between them.

Another explanation for the resistance from professionals towards volunteers could be that suggested by Netting et al. (2004), which asserts that community-centred approaches require a shift in power and control from professionals and organisations to local people. This can be

perceived as devaluing the role of the professional. Volunteers working within such approaches can be perceived by professionals as trying to take control from them and therefore react by resisting working with volunteers. This presents a challenge in implementing community-centred approaches and should be taken into account at the planning stages. McAllum (2018) studied the notions of professionalism and volunteerism in two healthcare settings; an organisation providing health checks for children under five years old and the St John's Ambulance. Her findings showed differences between the way professionalism and volunteerism were understood and acted upon. Volunteers and professionals in the first organisation defined distinct boundaries between them, with no opportunities for crossover. Volunteers in the second organisation, whilst able to cross boundaries and assume professionals' duties, faced resistance from professionals who felt that volunteers had not worked their way from novice through to expert, as they should (McAllum, 2018). It appears, therefore, that boundaries may facilitate better relationships between professionals and volunteers. However, it can be argued that, for professionals who have a top-down interpretation of their role (such as professionals with medical training), issues around working with volunteers can be expected.

3.5. Evidence for community-centred approaches in improving communities

One of the main criticisms of community-centred approaches in improving health outcomes is the lack of scientific evidence. It has been argued that the evidence base for community-centred approaches is weak due to the lack of Randomised Controlled Trials (RCTs) evaluating their effectiveness (McLean, 2012).

Indeed, the RCT evidence that exists is contradictory. Johnson, Howell and Molloy (1993) conducted an RCT looking at a non-professional intervention for new mothers. The programme used community mothers, trained them on child health issues (immunisations, cognitive

development, nutrition) and they worked alongside community nurses to support new mothers. Their study found that non-professionals were able to deliver this programme effectively. Children in the intervention group were more likely to have been immunised, they were more read to and their nutrition was better compared to controls (Johnson, Howell and Molloy, 1993). Although the study was not able to determine whether non-professionals were able to deliver the programme better than professionals, it supported the use of community-centred approaches. It has to be noted that this RCT was not blinded which increases the possibility of a biased study, thus constituting its findings less reliable.

Another RCT by Watt et al. (2009) found that volunteers had no significant effect on infant feeding practices. In this study, volunteers were trained in infant nutrition and conducted home visits to women in the intervention group. No significant differences were found between infants who received support from volunteers compared to standard care. Conversely, the women recruited in this study were not representative of the general population as a higher proportion were breastfeeding compared to the national average. Therefore, it could be argued that there were sample bias which affected the effectiveness of the intervention.

On the other hand, Kenyon et al. (2016) showed that there were benefits to adding support from lay workers for women at risk of post-natal depression compared to standard care. The study identified that women with two or more social risk factors benefitted more from lay support which supports the notion that such support can have increased benefits for disadvantaged people. However, this study had an important limitation; post-natal depression was not measured at baseline, and thus the findings relating to mental health improvements can be due to differences in maternal depression at baseline (Kenyon et al., 2016).

Olds et al. (2002) were also unable to detect significant effects of paraprofessionals on health outcomes for mothers and children compared to standard care. Although some of these findings

(Watt et al. 2009; Olds et al. 2002) can be interpreted as negative regarding volunteer involvement, they also show that expensively trained and remunerated professionals (standard care) and volunteers who have received a fraction of the training professionals have, can achieve the same results (Johnson, Howell and Molloy, 1993; Kenyon et al. 2016). Overall, if the fundamental principle underlying medical care is to "do no harm", and there is no evidence to show that volunteers perform worse than professionals, this could represent a significant cost saving in implementing programmes and could free up professionals' time to perform skilled work.

Furthermore, the complexity in trying to establish the effectiveness of such approaches, particularly on communities should not be underestimated. Concepts such as community empowerment, cohesion and social capital are inherent concepts for such approaches and are harder to define and measure compared to health outcomes (Sigerson & Gruer, 2011). In addition, all community-centred interventions influence and are influenced by numerous factors that any evaluative design would fail to capture in their totality (McLean, 2012). However, as Springett, Owens and Callaghan (2007) point out, the current dominant model for showing effectiveness is primarily based on epidemiological and experimental studies and it views experiential data as less compelling. Nevertheless, in order to understand the processes of community-centred approaches, experiential evidence around barriers, facilitators, implementation and delivery issues etcetera is essential (Trickett, et al., 2011). This evidence can be better captured by alternative experimental designs and in depth qualitative studies.

With regards to the qualitative evidence base, some studies have reported positive experiences of parents regarding receiving support from lay professionals (McLeish and Redshaw, 2015; Thomson, Balaam, and Hymers, 2015). Interestingly, both papers explored experiences of low income, disadvantaged mothers, therefore supporting one of the fundamental notions of

community-centred approaches, namely that they can be particularly beneficial for marginalised individuals.

One of the most recent, and most influential examples of community-centred approaches and their potential is the Bromley by Bow model (Stocks-Rankin, Seale and Mead, 2018). Bromley by Bow is a partnership between a community centre and a health partnership (in the form of three GP practices) that developed a model to support the local community. The model reaches and supports over 30,000 individuals with health needs as well as wider social determinants of health. Stocks-Rankin, Seale and Mead's (2018) qualitative research into the model identified six ways in which the model benefits local residents and ways in which it can help them in the future. By meeting residents' basic needs; connecting them to others; increasing their confidence; helping them contribute to the community; ensuring they are known and recognised; and connecting them to support and resources, the model aspires to aid community development. It aspires to help local residents to get involved in local decision making, reciprocate towards and support one another, have an increased sense of belonging and increased capacity to act on local issues (Stocks-Rankin, Seale and Mead, 2018). The qualitative evidence so far indicates that the model is working well and more research is being conducted.

With regards to other available evidence to date, a systematic review reported on 31 studies conducted in Australia. The review aimed to explore how community participation happens in community development programmes, appraise the research methods commonly used by studies and synthesise the results. Two studies had used quantitative methods with the majority of studies having used qualitative or mixed methodology research designs. The systematic review appraised the studies and concluded that the reporting of methods was poor and therefore it was not possible to determine the extent to which community participation happens

in community development projects. (Snijder, Shakeshaft, Wagemakers, Stephens, and Calabria, 2015). However, a scoping review which identified 128 relevant papers, found mostly positive results for communities (South, et al., 2017). In addition, a review of the evidence on the experiences of people who take part in community-centred approaches showed benefits for them, including increased sense of empowerment, increased confidence and self-esteem. However, the review also noted certain negative impacts on volunteers such as increased stress and fatigue (South, et al., 2017).

A multimethod systematic review conducted by O'Mara-Eves, et al. (2013) found community-centred interventions to be effective in a variety of contexts. Their recommendation was that community engagement efforts should be made in every public health intervention as it can have positive outcomes for people and communities. They also reported that community-centred approaches need to ensure that they are fit for purpose and avoid the pitfall of one-size fits all (O'Mara-Eves, et al., 2013; PHE and NHS England, 2015).

Research has also provided evidence for the value of assets and how they can benefit individuals, families and communities. Some have presented the case for the benefits of relationships and social networks, particularly regarding resilience and support (Morgan & Ziglio, 2007). Concepts such as social capital are reinforced by social network development and have been found to be increased by community-centred and volunteering initiatives. Taking this further, it has been shown that people with strong support networks have lower mortality rates compared to isolated people with no social networks (Holt-Lunstad, Smith, & Layton, 2010).

In addition, there are a number of studies on lay health trainers and their ability to influence change in health and community outcomes, particularly in areas of disadvantage. White, Woodward and South (2013) synthesised data from eight evaluations of health trainer

programmes and found that health trainers are able to reach people in disadvantaged areas and help them make lifestyle changes. Visram, Clarke and White (2014) reported similar results after evaluating three health trainer services targeting disadvantaged areas in the North of England. Their findings indicated that health trainers can be successful in enabling people from disadvantaged communities make lifestyle changes and maintain them.

However, Murphy, Cupples, Percy, Halliday and Steward's (2008) study found difficulties in implementing programmes delivered by lay health workers to new mothers in areas of socio-economic deprivation. They found that making contact with new mothers, developing a relationship between lay health workers and mothers and time constraints were dominant issues. Despite the fact that lay health workers were from the same community as the mothers they were trying to support, initiating contact with them and developing a relationship was an issue. On the other hand, evidence from the USA show that lay health workers are effective when delivering outreach family based interventions around smoking cessation, physical activity and healthy eating (Burke et al., 2018). The reasons for their effectiveness, according to the study, lie in their ability to use different strategies to engage with people and making the health messages relevant to them.

Similarly, Kennedy's (2010) study of lay health workers with a role in promoting healthy eating in disadvantaged areas, found numerous benefits attributed to lay health workers at a service, personal and community level. The service was able to support more people and therefore was able to support the "hard to reach", the lay health workers were able to develop both personally and professionally and the community received better support.

Particularly with regards to the benefits to the lay health workers, in a review of nineteen community-centred projects, it was found that individuals showed increased confidence as a result of their participation and they felt that they personally benefitted from volunteering and

peer support opportunities (Mclean & McNeice, 2012). All nineteen projects were local initiatives implemented in Scotland and evaluated using qualitative methods, thus rendering their results context and locality specific. Reports from such initiatives are helpful in shedding light on the intricacies of community-centred programmes, particularly around the way they are experienced by the actors within them (individuals in the community, professionals and other stakeholders). Some evidence has shown that professionals involved in community-centred approaches understand (theoretically) the underlying principles of giving control back to communities, working from the bottom-up as opposed to top-down and recognising the importance of local assets (McLean & McNeice, 2012). Nevertheless, there is no evidence that they implement or promote these principles in practice (McNeish, Scott, & Williams, 2016).

Despite, therefore, some evidence to suggest that certain aspects of community-centred approaches have worked relatively well for individuals within communities, there is a general lack of evidence with regards to the approach, particularly around community outcomes (Mclean & McNeice, 2012). This could be due to the research design issues mentioned earlier or due to the fact that community development happens over the course of several years and more time is needed for its impact to be apparent (Kretzmann & McKnight, 1993). Another reason for the apparent lack of evidence could be due to the definitional issues that have been explored throughout this and previous chapters. Given the plethora of terms such as community development, community empowerment, volunteers, capacity building, community-centred, community-based etcetera, identifying a unified evidence base is challenging (South, et al., 2017). Perhaps if the definitions for such terms were widely accepted the evidence base would be easier to navigate.

Regardless of the reasons, the evidence base for community-centred approaches is relatively weak. Research on community-centred approaches indicates that they are not a “quick fix”

approach and require several years before their outputs can be visible and tangible. Community empowerment and capacity building take time and therefore such approaches may appear unsuccessful when evaluated over a short period of time. However, the use of such approaches can have a snowballing effect, whereby activities which aim to empower communities may appear unimportant in the short term but have greater impact in the long term (Kretzmann & McKnight, 1993). Due to this, and because community-centred approaches require a shift in power and control from professionals to communities, they can be challenging for professionals to implement. For those professionals who are used to working within top-down approaches, this shift in power, decision making and control can be perceived as diminishing of their professionalism and expertise (Netting, Nelson, Borders, & Huber, 2004).

It is a common misconception that community-centred approaches can be used as cheap alternatives to statutory service provision. However, research shows that they require significant initial investment in order to achieve the desired outcomes as described above (Allen, 2011). From supporting communities and networks in working together to up-skilling professionals in working with communities following a community-centred approach, the initial investment should not be understated. However, Marmot's review (2010) argues that, in the long term, community-centred approaches are worth the investment, as the reduction in need for statutory service provision can be significant (Marmot, 2010).

To this end, a review of Social Return on Investment (SROI) analyses of seven studies which used community-centred approaches showed a positive return on investment, which means that the community-centred approaches created significant savings when implemented compared to the initial investment. Although the authors of the review recognise that these studies may have been available due to publication bias (i.e. they were reported because they showed

positive return on investment), they concluded that community-centred approaches can result in financial (as well as other) benefits (Dates, Mallender, Pritchard and Rtveladze, 2015).

Generally, therefore, the evidence base for community-centred approaches is somewhat weak. This could be due to evaluative and research designs used to determine effectiveness, due to the relatively short timescale for which they are implemented or the fact that the crucial shift to bottom-up approaches is yet to be accepted by professionals working within such approaches. However, given that community-centred approaches are currently being utilised as intervention approaches rather than normal practices, the inability to determine their benefits for public health and community outcomes could be due to development and implementation issues.

3.6. Development and implementation of community-centred approaches as interventions

Community-centred approaches can be thought of as complex interventions. Complex interventions are generally defined as interventions that have numerous components and actors that need to interact for the interventions to be deemed successful (Moore, et al., 2015) Although it can be argued that all interventions involve a certain element of complexity, the context, setting, number of people and systems involved can make an intervention highly complex (Craig, Dieppe, Macintyre, Michie, Nazareth and Petticrew, 2013). A good example to illustrate this point is Sure Start. Sure Start was a UK wide intervention which aimed to give children the best possible start in life through improving childcare, early education and health. In addition, Sure Start provided family support and promoted outreach and community development. This is a highly complex intervention compared, say, to a flu vaccination intervention where vulnerable groups are targeted to receive the vaccine free of charge.

The reasons for this complexity lie in the number of interacting components (numerous settings, numerous staff, numerous systems), in the difficulty of behaviours targeted (improvements in health, education and family lives), the number of groups targeted (parents, children, staff across organisations) and the number and variability of outcomes (community development, health improvement, better childcare, better education, best possible start in life) (Moore, et al., 2015). Moreover, factors external to the intervention add a further layer of complexity; local and national governments and policies can have a major impact, as can deprivation, employment opportunities, wider economic, social historical and psychosocial factors (May, Johnson, and Finch, 2016). Therefore, a community-centred approach as outlined above is a complex intervention.

The way in which complex interventions need to be developed has received a lot of attention from scholars around the world. Given the popularity of, and the need for, complex interventions, there is a need to know whether they are effective, why they are effective and how they can be scaled up or replicated to other settings or contexts (Bleijenberg, et al., 2016). The Medical Research Council (MRC) guidance for developing and evaluating complex interventions suggests that interventions need to be developed systematically, based on the best available evidence and well outlined theoretical underpinnings (Moore, et al., 2015). A complex intervention based on theory is more likely to be successful in achieving good results (May, Johnson, and Finch, 2016).

The MRC guidance provides a useful description of the stages involved from the development through to implementation of complex interventions. These stages are presented and described below:

- Development (identification of the theory that will inform the intervention and the evidence base around it)
- Feasibility/piloting (testing of procedures, identification of the necessary sample size, recruitment and retention of participants/target groups)
- Evaluation (assessment of effectiveness, cost-effectiveness and understanding of the change process)
- Implementation (dissemination, monitoring, follow up in the long term) (Moore, et al., 2015)

Although these stages are useful in providing a process to follow, practical, logistical or financial circumstances may render following each stage in a linear fashion impossible (May, Johnson, and Finch, 2016). Consequently, in some cases the evaluation may take place after implementation, the identification of theory may not happen during the development stage (if at all) and feasibility/piloting may not always be possible, often being seen as an unnecessary and expensive adjunct. In addition, the MRC report has been criticised because it fails to provide detailed guidance on how to progress through the stages. For example, the identification of a theory that will inform the development of an intervention can be challenging and time consuming and the report fails to provide a systematic way of ensuring that the most appropriate theory is identified (French, et al., 2012).

Nevertheless, even in the absence of a recognised theory, when an intervention is in the development stage, its stakeholders know what they are trying to address, tackle or improve and have (implicit) ideas (or theories) about how they are going to do it. Those ideas are then used to decipher what activities need to be in place and what behaviours need to be observed to determine that an intervention is working (or not working). This is the theory of change; the theory of how the intervention will achieve what it aims to achieve (De Silva, et al., 2014).

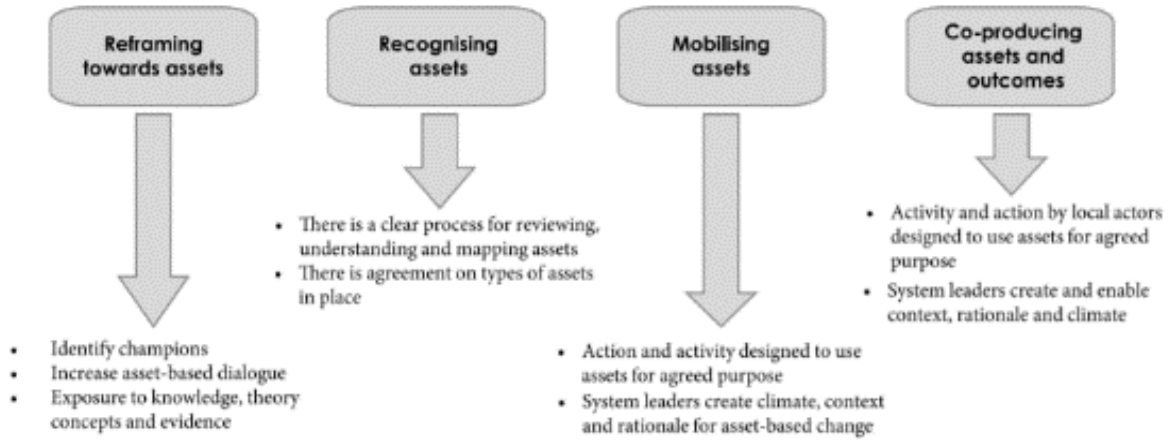
White (2009) defined the theory of change as a map which outlines the causal links between the inputs, activities, outputs, outcomes and impacts of an intervention, including the fundamental assumptions made throughout the process. Assumptions are key to all theories. In fact, the very existence of intervention approaches is based on the assumption that there is a need to intervene to help people. Identifying those assumptions from the outset makes the process of identifying parts of the intervention that worked well easier, particularly for people who were external to the intervention itself (White, 2009). However, as researchers have previously pointed out, the inclusion and consideration of the theory of change or any theory during the development and implementation of interventions is not always common practice and many interventions are based on empirical or pragmatic approaches rather than evidence and robust theories (Albarracin, Gillette, Earl, Durantini and Moon-Ho, 2005; Eccles, Grimshaw, Walker, Johnston, and Pitts, 2005).

This is problematic because a theory can help deduce how behaviour change happens and what mechanisms are involved in that change. Without an explicit theory of how an intervention is supposed to work, evaluation and monitoring are difficult, as it is impossible to unpick the process, procedure and mechanisms that led (or failed to lead) to change (White, 2009). Thus, the evidence base for interventions weakens, as there is a lack of thoroughly evaluated interventions. Perhaps more importantly, the lack of strong evidence impedes evidence based practice and results in resources and time being spent on potentially unsuccessful interventions (Evans, Scourfield and Murphy, 2014b).

In the field of community-centred approaches in public health, a theory of change was originally proposed by Hopkins and Rippon (2015). In their report “Head, heart and hands: Asset-based approaches in health and care” they devised a theory which could be used to guide

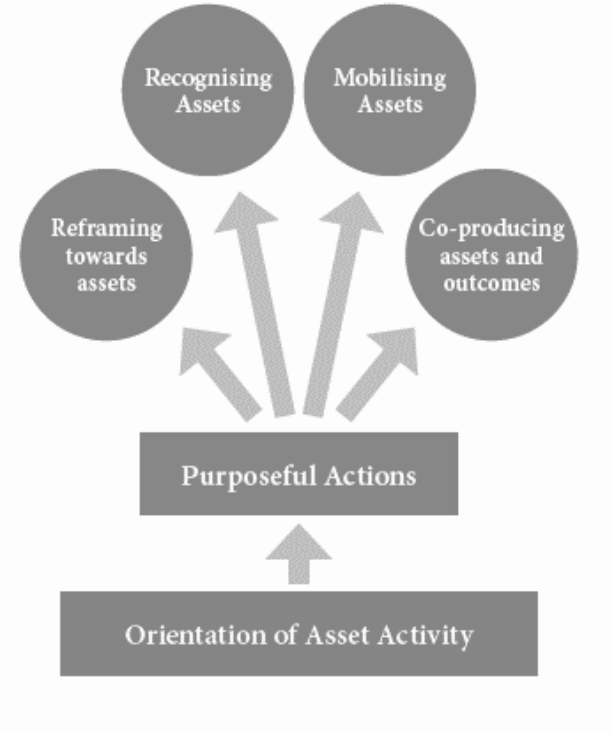
the thinking and development of community-centred approaches placing particular emphasis on assets. The original theory of change can be seen in Figure 3.2.

Figure 3.2.: The theory of change for asset-based approaches (Hopkins and Rippon, 2015, p.p. 22)



This theory of change proposes four stages which can help focus a community-centred approach and reframe the thinking towards assets rather than deficits. The creators of the theory of change posit that, although these stages are not linear, they can help provide a plan for community-centred approaches with a focus on assets. In an attempt to take this theory of change forward and develop it further, Rippon and South recently published a revised version of this theory informed by interviews, observations, workshops and literature reviews. The revised theory is presented in Figure 3.3.

Figure 3.3.: The revised theory of change for asset-based community approaches (Rippon and South, 2017, p.p. 14)



Although the theory is largely similar to the original version, it emphasises the need for purposeful actions and orientation of asset activity. Purposeful actions refer to the actions that have to be taken for specific purposes; the adoption of participatory approaches to facilitate engagement from different types of stakeholders, the mapping of existing assets to understand the local context are some examples of purposeful actions (Rippon and South, 2017). With regards to the addition of orientation of asset activity, Rippon and South's (2017) research showed that participants in community-centred approaches needed an understanding of the reasons for the adoption and the evidence base behind such approaches, in order to fully understand how to work within them, what is expected of them and, most importantly, what shifts are required for such approaches to work. This is a crucial point which has been identified elsewhere in the literature. For example, Normalisation Process Theory also posits that understanding the rationale for an innovation or initiative is the first step towards its normalisation; one cannot subscribe to a new way of working without understanding why, and what is expected of them (May et al., 2009). This theory of change can be valuable for the

development of community-centred approaches but may also be useful as a tool to investigate the extent to which a community-centred approach was truly asset based, thus constituting it particularly relevant to this study. Section 8.1.1 of the thesis appraises these theories for their usefulness in exploring the programme under investigation.

This section aimed to make the case as to why community-centred approaches should be thought of as complex interventions. Moreover, it aimed to emphasise the importance of the development stage of community-centred approaches and particularly the need for a theory of change to guide the approach through its implementation and delivery phases. This was pertinent to this study, as will be shown in the following chapters.

3.7. Summary

To summarise this section, a community is a group of people sharing common interests that could be geographically close or not. Community development is a process intending to improve certain outcomes within a community. The way in which this is achieved can take several forms, with two approaches being particularly popular; top-down and bottom-up approaches. Top-down are the needs-based approaches whereby needs are identified by agencies outside the community and are tackled by those agencies. Bottom-up approaches are community-centred approaches which recognise that identifying and mobilising assets can result in better outcomes for health and wellbeing. Community assets are forms of capital that exist within a community (relationships, networks, physical space, availability of funding). Lastly, community empowerment is the process by which, having identified and mobilised its assets, and built capacity, that is individuals understanding of the community's issues, the community (or individuals within it) come together to take control over distribution of resources to tackle the issues.

From a public health point of view, this way of thinking about and working with communities came about after the realisation that health and wellbeing do not exist in a vacuum; they influence and are influenced by wider social determinants (PHE and NHS England, 2015). Social capital in particular has been found to have an impact on health both mental and physical health (Ferlander, 2007). It is therefore recognised that, by increasing social capital through community-centred approaches, the wider social determinants of health can be addressed and subsequently lead to better health and wellbeing (Glasgow Centre for Population Health, 2017). Therefore, a plethora of community-centred approaches have been developed in public health which aim to address the wider social determinants; these are presented next.

Community-centred approaches can be broadly categorised into four strands based primarily on the outcomes they aim to achieve; strengthening communities, developing volunteer/peer roles, building collaboration and partnerships and promoting access to community resources. All approaches use assets to achieve their outcomes. Volunteering within these approaches has been found to help both volunteers and communities in general. However, it does present with challenges, the most important of which is professionals' resistance to working with volunteers.

The evidence base for community-centred approaches can be considered weak, particularly in the current model for evidence of effectiveness. Large experimental studies which "prove" effectiveness do not exist, mainly because of the inherent difficulties in using such research designs in community settings and due to the intricacies and long term nature of the interventions themselves which can be lost in such a design. However, there is a strong evidence base for the positive impacts of community-centred approaches on volunteers, and communities as well as their positive return on investment.

The development and implementation of community-centred approaches thought of as complex interventions was also explored in this chapter, given that the way in which a

community-centred approach is developed and implemented can be very influential for its success.

3.8. Conclusions from the literature

The literature review on volunteering and community-centred approaches provided some insights into the pertinent subjects of this thesis. The political overview of volunteering in post-war Britain showed how central volunteering has been on governments' agendas. Volunteering has been advocated from both Conservative and Labour governments as a means to promote community cohesion and empowerment, with a view to move away from relying solely on state provision and start relying on communities to help themselves. Despite the lack of a universally agreed definition on volunteering, academic disciplines explore volunteering based on the motives behind it. The wider debate centres on whether it is an altruistic or egotistical act, whether it is based on the desire to help the collective or oneself. Economics, psychology and sociology offer theories and research which can support either of these arguments thus illustrating its complex nature. However, public health offers a different standpoint to volunteering. Rather than focussing on the academic debate of its nature, and accepting that volunteering can be used to improve community health and wellbeing, public health provides practical approaches to utilising it.

Public health understands volunteering as a noble act that can benefit the volunteer, the community and the state, particularly in times of austerity. It posits that individuals in communities are assets that are able to both improve the health and wellbeing of a community as well as help the community develop. To this end, community-centred approaches have been developed within public health, which aim to harness the knowledge and capital within communities and use it in order to influence change. Several community-centred approaches exist, many of which rely on volunteers to support them. The evidence for the effectiveness of

such approaches is relatively weak but some studies have found promising evidence both in terms of the ability of volunteers to improve health and wellbeing as well as in terms of their cost effectiveness.

These reviews however, also identified some gaps in the literature which this thesis aimed to address. Firstly, although there is a wealth of theories and disciplinary lenses which explain volunteering, there is a lack of evidence around how volunteering is understood more widely. Studies have explored the general public's views on volunteering as well as volunteers themselves, however, few studies have explored the notions and understandings around volunteering in depth. Exploring the way volunteering is understood outside of academia and research is important and it is bound to influence community-centred approaches given that they are designed and implemented largely by people outside of academia and research. Understanding the way in which volunteering is constructed by people within communities (professionals, volunteers and the general public) is therefore vital because it influences the way in which volunteering programmes are implemented and utilised.

In addition, the literature provides excellent overviews and descriptions of community-centred approaches, their elements and the way they are supposed to work. Some insights are provided into elements that can influence such approaches; the frictions between professionals and volunteers have been documented, as have issues with resistance from the community itself. However, and acknowledging the fact that every community-centred approach will be different depending on the community(ies) and context(s) in which it exists, the elements that influence a community-centred approach will also be different. Any study which explores those elements therefore is vital as it adds to the evidence base and can have important implications for future approaches.

Another gap in the literature is around the way in which community-centred programmes are expected to influence change. Although the different approaches have been thoroughly described, the way in which they influence or are supposed to influence communities is unclear. The notions of community development and empowerment are dominant in such approaches, yet little is known as to how a community-centred approach that uses volunteers is going to empower the community and aid its development. Therefore, understanding the processes is vital.

Lastly, the literature provides some evidence around how community-centred approaches impact the community. Studies have shown improvements in health outcomes as well as increased resilience, sense of belonging and community cohesion. However, most of these studies focussed on either the volunteers or the targeted groups of the approaches (parents, marginalised groups etc). Professionals and people who design, fund and implement the approaches are often overlooked in research despite the fact that they are as instrumental in community-centred approaches as volunteers.

Although the links between community-centred approaches and complex interventions have not been made explicit in the literature, this thesis argues that thinking of such approaches as complex interventions can provide another layer of exploration. Given that a complex intervention requires multiple components to interact with each other in order to produce change, and the fact that community-centred approaches require collaboration on many levels and settings, exploring the development and implementation of community-centred approaches can provide valuable insights into their intricacies and mechanisms of change. Notably, the theory of change for such approaches and the underlying principles which guide their implementation can be instrumental in their success or failure.

This study therefore, using a community-centred approach as a case study, fills these gaps and adds to the evidence base around both volunteering and community-centred approaches. The learning from this study has wider implications for literature, research and, most importantly, practice. The next section of the thesis will present the case study and the methodology before introducing the findings.

4. Chapter Four: The Fairer Start Volunteer Programme (FSVP)

This chapter presents the community-centred volunteer programme that was studied. It provides the regional and local context for the study, presents the wider intervention that the volunteer programme was part of and outlines the volunteer programme. Following the thorough portrayal of the programme, it utilises a descriptive framework to provide clarity around volunteer roles in a structured manner.

4.1. Regional Context

The programme under exploration was implemented in a deprived ward in Stockton-on-Tees, a local authority in the North East of England. Before outlining the local context, it is useful to provide a wider picture of the North East, from a public health point of view, in order to provide the background of the programme.

As a region, the North East is amongst the most deprived in England. Life expectancy is approximately 2 years less for both males and females compared to the national average (77.9 for males and 81.6 for females compared to 79.6 and 83.1 respectively). Alcohol-specific hospital stays, smoking prevalence and obesity are higher than national averages. The percentage of children in low-income families is higher than the England average (22% compared to 16.8%) and the employment rate is lower than the national average (71% compared to 75.2%) (Public Health England Local Authority Profiles, 2019).

With regards to Stockton-on-Tees local authority, it is a relatively deprived local authority with a score of 24.6 compared to 21.8 for England. Life expectancy is lower for both males and females and behaviours such as heavy alcohol consumption, smoking and unhealthy eating are prevalent (Public Health England Local Authority Profiles, 2019). Health inequalities are

extensive in the area with people in the affluent areas of the town having an 18-year longer life expectancy compared to those in the least affluent areas.

Aside from the public health data, migration data are also relevant. In 2015/16, Stockton-on-Tees saw an inflow of 1,093 international immigrants and an outflow of 378 (ONS, Migration Indicators Suite, 2018). Generally, over the last decade, Stockton-on-Tees has consistently had high levels of foreign nationals settling in the area (Joint Strategic Needs Assessment Stockton, 2016). Public health as well as migration issues were two of the main issues that justified the need for a new programme to be developed.

4.2. Local Context

At the time of the design of the programme, the Stockton Town Centre ward within the town of Stockton-On-Tees was the most deprived area in the Borough. It had approximately 6,500 residents. The ward had high levels of children living in poverty (47.6% compared to 28% nationally) (Joint Strategic Needs Assessment Stockton, 2016). Moreover, the ward included high numbers of children in need and looked after children (13.6% compared to 4.9% borough-wide) as well as relatively high numbers of children who were registered with the Common Assessment Framework (CAF) (10.4% compared to 3.9% borough-wide). Deprivation was also linked to the high levels of parental substance abuse and the problem of domestic violence in the ward.

With regards to children's development and based on the Early Years Foundation Stage (EYFS) Profile, only 31% of children in the ward achieved good levels of development, compared to 50% borough-wide in 2014. This indicator rose to 47% in 2015 but remained below the borough-wide figure of 59%.

Based on data gathered by the commissioning organisation in 2015, breastfeeding rates were also an issue in the ward, as only half (51.5%) of the mothers initiated breastfeeding at birth, compared to the borough-wide figure (57.6%). Breastfeeding at 6-8 weeks was better compared to the rest of the borough, with 43.2% of mothers continuing to breastfeed in the Town centre, compared to 29.8% borough-wide. With regards to children's weight, 25.8% of children in the Town Centre ward were either overweight or obese in Reception year (similar to the figure for Stockton on Tees; 24.7%). Maternal obesity was worse in the ward (34.2%), compared to the borough (31.7%). Lastly, 25% of mothers in the ward were smoking at delivery (16.7% borough-wide) and 18.2% quit smoking at pregnancy compared to 24.7% for Stockton.

As a result of these and other concomitant issues, only 50% of children were able to achieve measures of school readiness at the appropriate age (Joint Strategic Needs Assessment Stockton, 2016). Taking this demographic profile into account, along with the desire to give children the best start in life, it was decided that the intervention would be piloted in this particular ward. The following section will outline what A Fairer Start was and what it aimed to achieve.

4.3. Background

The idea for A Fairer Start (AFS) arose from the joint effort of Stockton on Tees Borough Council, Public Health Early Intervention, Hartlepool and Stockton on Tees Clinical Commissioning Group (CCG) and Catalyst to develop a bid for the Big Lottery Fund in 2014. Catalyst is a strategic infrastructure organisation for Stockton-on-Tees, committed to providing an effective voice, representation and support for the voluntary, community and social enterprise sector (Stockton Information Directory, 2018). Big Lottery Fund was offering - through a system of competitive bidding - a total budget of £215 million to be divided between five localities that needed support in order to improve outcomes for children 0-3 years old and

their families through system change. More specifically, the fund called for proposals to improve social and emotional development, communication and language, and nutrition. It aimed to create "a shift in culture and spending across children's and families agencies towards prevention, so that local health and other public services, Voluntary, Community and Social Enterprises (VCSE) and the wider community could work together to co-produce and deliver less bureaucratic, more joined-up services for all families living in the area." (Big Lottery Fund UK, 2015).

The aforementioned partners worked together in order to develop the bid which, although it passed the initial stage, was ultimately unsuccessful. At that point, Stockton Council Public Health and Hartlepool & Stockton-on-Tees Clinical Commissioning Group, having worked themselves into a state of enthusiasm for such an initiative, decided that they did not want to lose the idea and therefore awarded £250,000 for a 3 year "A Fairer Start" (AFS) programme. Although this was a significant investment in the area, particularly given the limited local authority budgets, it was considerably less than the £40 million investment that was expected from the Big Lottery Fund. However, the ambition and enthusiasm for the AFS programme remained significant. The initiative was to be implemented initially as a pilot, with the potential of a borough-wide roll out after three years. After a thorough examination of demographics and public health needs as outlined in the previous section, it was decided that Stockton Town Centre ward would be the best place to implement the initiative.

With regards to the partners involved in the design, implementation and delivery of AFS, Catalyst was the main organisation that held the funding and oversaw the initiative. Catalyst's vision was that of a coherent and single voluntary sector, working together in partnership to shape and deliver the services the community in Stockton-on-Tees need. Their aim was to build on the ethos of support and partnership inherent within the voluntary sector by extending this

to enable organisations to work together (Stockton Information Directory, 2018). Catalyst was heavily involved in designing, implementing and delivering AFS, commissioned work packages to different organisations and oversaw and managed the initiative in its totality.

4.4. A Fairer Start

In its inception, the overall aim of AFS was to improve the school readiness of children in Stockton Town Centre through improving three key outcomes: cognitive, social and emotional development, speech and language, and nutrition. By improving these outcomes it was hoped that health inequalities would be reduced and health and wellbeing would be improved for children and their families ('A Fairer Start' Project Brief, no date).

The recommendations proposed in the independent report "Conception to age of opportunity" by the WAVE Trust provided the focus for AFS (Department of Education and WAVE Trust, 2013). It is worth mentioning that this report was not commissioned by or linked to AFS in any way; it was written independently. The stakeholders involved in the development of AFS felt that the report's recommendations would be a good guide for the outcomes that AFS needed to achieve. According to that report, in order to reduce inequalities and provide children with the best start in life, ten areas of support would have to be targeted ('A Fairer Start' Project Brief, no date):

1. Increase breastfeeding and good antenatal nutrition
2. Promote language development
3. Reduce domestic violence; and stress in pregnancy
4. Achieve a major reduction in abuse and neglect
5. Set up an effective and comprehensive perinatal mental health service

6. Assess and identify where help is needed

7. Focus on improving attunement (connectedness between parents and children)

8. Promote secure attachment

9. Ensure good, health-led multi-agency work

10. Ensure early years workforce have requisite skills

With these areas for support providing the focus of AFS and the ultimate outcomes that it aimed to achieve, AFS was developed to:

- Systematically identify and target children, families and communities;
- Holistically assess individual needs;
- Provide tailored packages of support;
- Develop local community champions and raise awareness within communities;
- Develop systems and processes to provide a central point of contact, coordination, referral routes and follow-up, tracking and monitoring ('A Fairer Start' project brief, no date).

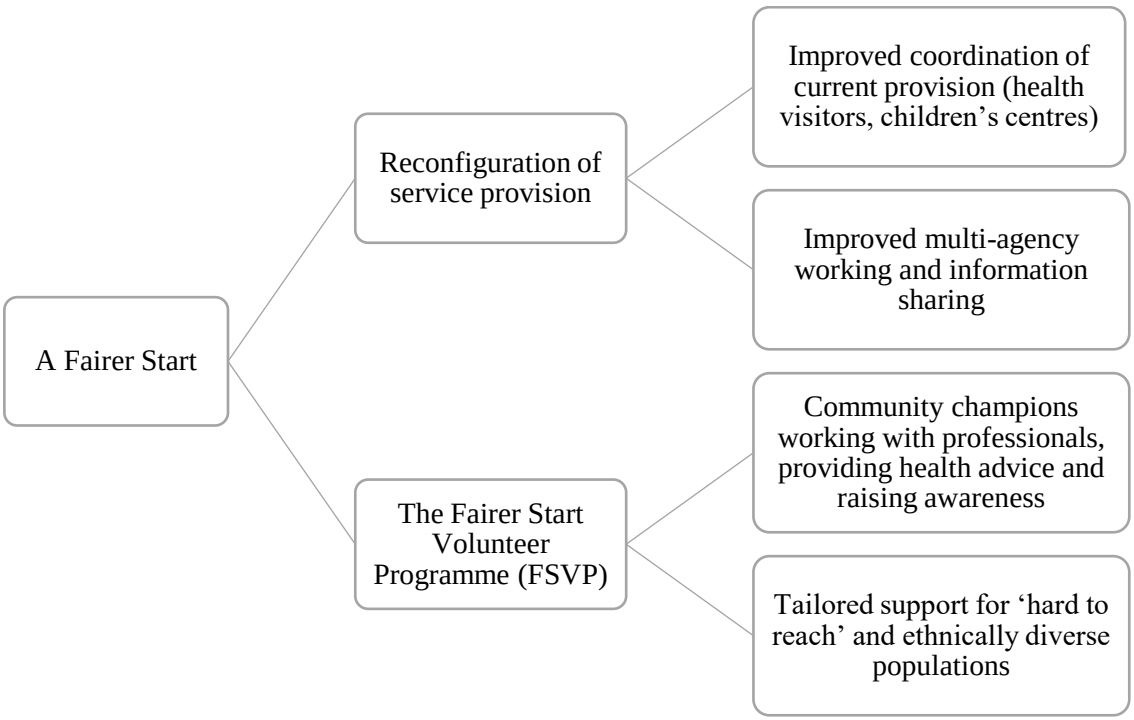
Reconfiguration of current service provision was deemed necessary in order to improve these outcomes. This was to be achieved in two ways: firstly by integrating and changing systems within existing services (health and social care, children's centres, etc.), and secondly, by empowering communities through a community champion volunteering programme. Both aspects of work were led by Catalyst, although the champion volunteering programme was commissioned out to Big Life Families (BLF) - a local social enterprise which delivered high

quality, welcoming support and services to the families who need it most (The Big Life Group, 2018).

It is important to note that AFS evolved and changed throughout its implementation. The evolution of such approaches during their implementation is hardly unexpected (Craig, Dieppe, Macintyre, Michie, Nazareth and Petticrew, 2008); in order to respond to the needs of communities and particularly when numerous partners are involved, adaptability and change are essential. In the case of AFS, although the ultimate goal was to improve outcomes for children and families, it became apparent that it was unrealistic to expect that this would happen in three years. In addition, it was felt that the steps that were taken during the implementation phases (for example, ensuring information sharing between partners) for Stockton Town Centre, could be replicated across the borough and result in better communication for everyone. Therefore, it was decided to implement change wherever it was possible.

This led to AFS becoming "an ethos and philosophy that aims to ensure better life chances for 0-3 year olds through culture change, awareness raising, knowledge building and empowering communities to raise children in a healthy and happy environment" (Catalyst Stockton-on-Tees, no date). Given the complex nature of AFS, Figure 4.1. has been developed to illustrate it and its elements.

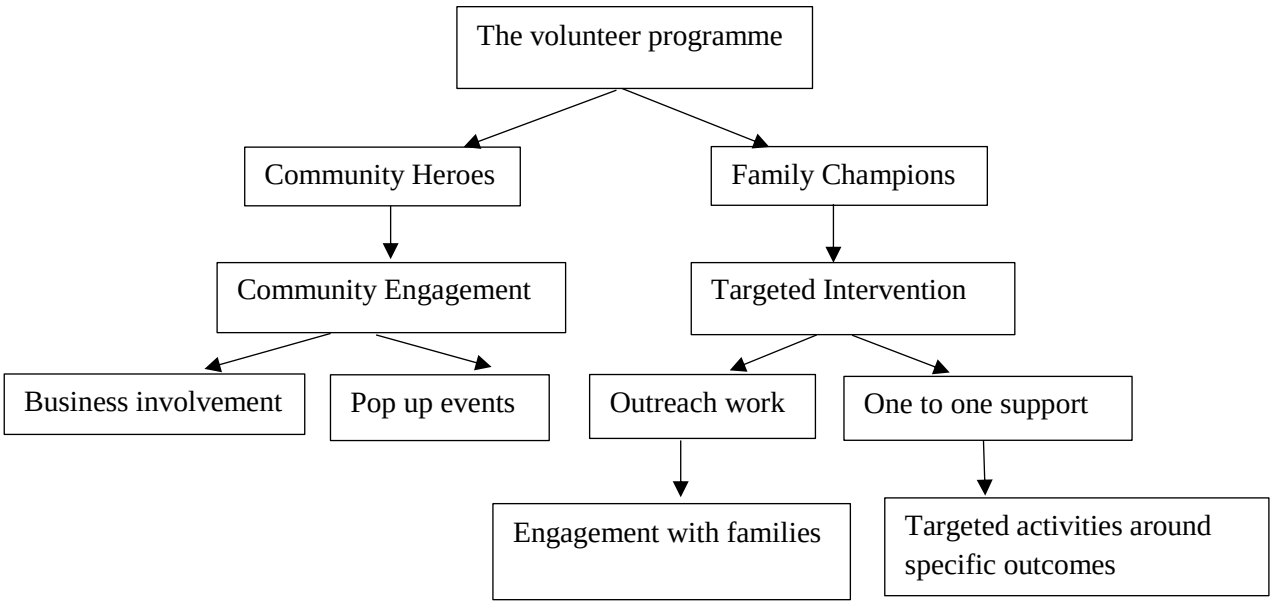
Figure 4.1.: A Fairer Start



*4.5. The Fairer Start Volunteer Programme (**FSVP**)*

In its inception, FSVP was a broad, public health intervention, which aimed to aid AFS to achieve its three main outcomes: improve cognitive, social and emotional development, speech and language, and nutrition of 0-3 year olds in Stockton Town Centre. In the section that follows, FSVP is described in as much detail as possible, giving emphasis on what it was envisaged to achieve and how it was designed to achieve it. Chapter 6 and particularly section 6.2 will present the critical analysis of FSVP in terms of how it was actually implemented, what it achieved, what it failed to achieve and some of the reasons behind the successes and the failures. The programme is shown in figure 4.2. It is worthy to note that this figure was created by me, the researcher, and not the leaders of the programme.

Figure 4.2.: The FSVP



4.5.1. The vision and approach

The vision for the programme was to impact on the community as a whole, help the community develop and be empowered; the community was defined as consisting of children, families, businesses and agencies (Butler, 2015). It was designed to work with the community particularly around improving access to local health services, providing information and signposting to local services. In order to achieve these aims, the FSVP created **two groups of volunteers**. One group was led by an early years qualified leader and worked closely with children and families; these volunteers were initially called **Family Champions**. The second group was led by a team leader and worked within the community; these were termed **Community Heroes**. The programme was overseen by a volunteer community partnership steering group, which acted as decision maker and co-designed the delivery and the direction of the programme (Butler, 2015).

Family Champions were part of the targeted intervention element of the programme whereby their role was to deliver support to families and children based on early years and health training they received. Community Heroes were part of the community engagement element of the programme. Community Heroes were responsible for organising and delivering pop-up events around the Town Centre which aimed to engage with children and families and provide advice and information. Heroes were also trained, albeit at a lower level than Champions and, based on their training, ensured that all pop-up events were targeting cognitive development, nutrition or speech and language (Butler, 2015).

4.5.2. Community engagement, empowerment and development

The community engagement, empowerment and development element of the programme, had two parts; a part for local business involvement and a part for community pop-up events around the Town Centre. Businesses were asked to sign up to the AFS charter, which signified their commitment to the programme. They were asked to establish child friendly environments/areas and display information, posters and leaflets provided by the programme. Businesses showed their support by donating goods or services to be used as rewards for volunteers, donating goods or services to help support pop up events, organising volunteer workforces to support Fairer Start events and promoting the programme to their own staff, friends and family. In return for their support, businesses featured on the programme's banners at the entrance to the town, were promoted on social media and in the press, and given promotional material to display to their customers.

Moreover, the programme's leaders worked with businesses to develop work experience roles for volunteers and approached local charity shops to support volunteers to work within their shops. The purpose of this was twofold; the volunteers could gain experience whilst simultaneously having the opportunity to speak to the community and promote the programme.

Businesses that signed up committed to having a "Fairer Start Friday", a day when supermarkets provided healthy eating giveaways, health and wellbeing prize draws and had dedicated space where families could pick up flyers, leaflets and general information about the programme. Lastly, loyalty cards were created, whereby families could get them stamped every time they bought something on Fairer Start Friday from a set list of items (i.e. healthy food for children) and which could be exchanged for free items from participating businesses (Butler, 2015).

The second part of the community engagement element of the programme involved community pop-up events. Their main purpose was to increase the visibility of AFS in the community, to give the volunteers a chance to engage with the community and to attempt to register "hard to reach" families with children's centres. The activities during community pop-up events were designed to teach parents the importance of playing with their children, particularly for their cognitive development, the importance of reading for language development and the importance of healthy eating (Butler, 2015).

4.5.3. Targeted intervention

In terms of the targeted intervention element, volunteers were recruited and trained to work alongside professionals such as Health Visitors, Midwives and Children's Centres early years workers. In addition, they conducted outreach work within the Town Centre area. This element targeted approximately 290 families that were identified as not being registered with Children's Centres. The families were identified based on data from registered births and lack of registered families with the Children's Centres in the area. There were, therefore, approximately 290 babies delivered whose families were not known to the Children's Centres. These were the families targeted by the programme.

The volunteers' work involved outreach work and one to one support. Outreach work aimed to facilitate engagement with children and families and one to one support assisted parents by providing targeted activities to improve specific outcomes (cognitive, social and emotional development, speech, language and nutrition) (Butler, 2015).

Several groups of people were identified as being in need for this targeted, more intensive support; lone parents, Black and Minority Ethnic (BME) families, vulnerable young parents (new to the area) and low income families were all seen as priorities. The creators of the programme argued that tailoring services to suit families' needs, employing a diverse workforce that could engage with a variety of people, targeting individuals in need and adopting a person centred approach would empower individuals to reflect, take control and bring about change by increasing self-efficacy and resilience (Butler, 2015).

4.5.4. Volunteers

The volunteers in the programme were naturally the most vital aspect of the intervention. Volunteers were viewed as a key resource in achieving lasting change and impact on the quality of life for individuals, families, groups and ultimately communities as a whole. The programme targeted certain people within the community to recruit as volunteers:

- the unemployed
- retired professionals with life experience
- parents with children in school and daycare
- BME individuals
- individuals with experience of mental health issues and substance misuse,
- people with an early years background
- individuals who are well known in the local community within Stockton

- older people (grandparents) with community and/or family standing (Butler, 2015)

All volunteers were required to complete an I-statement; a tool that helped volunteer coordinators to form a picture of the person, what skills they could offer, what aspirations they had and how they wanted to make a difference. It was argued that I-statements were tools that aided the empowerment of the individual as they recorded the volunteer's progress through the programme, thus enabling the volunteer to see and measure their successes (Butler, 2015).

Big Life Families (BLF) also claimed that volunteers in the programme needed to be able to influence their communities, act as the catalysts to empower change and make a difference whilst being able to take on new personal learning and understanding. Therefore, a training programme was offered which included general training around safeguarding, health and safety, information governance and risk assessments. In addition, all volunteers received training on health improvement and health in early years. Volunteers working on a one to one basis with families and children were trained on early years and early development for 0-3 year olds (Butler, 2015). The requirement for volunteers to attend the relevant training courses was outlined in a job description that they had to sign. All successful volunteers were Disclosure and Barring Service (DBS) checked prior to commencing work and two references from previous employers, friends, family or other professionals were required.

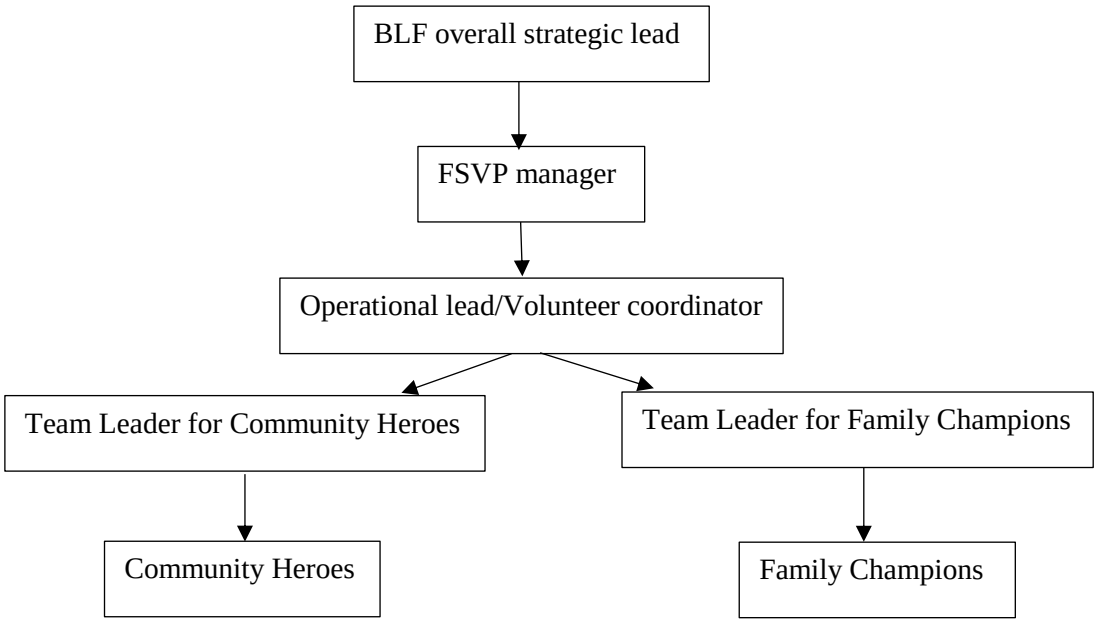
Moreover, volunteers received support during their time in the programme. More specifically, following completion of the I-statement, all volunteers created individual personal development plans which outlined their personal goals. These were reviewed regularly during supervisions so that volunteers could track their progress. In terms of supervisions, all volunteers received group supervision every 6 weeks and one-to-one supervisions when needed (Butler, 2015). Volunteers were able to access additional training sessions on a variety of

subjects provided by BLF and had access to internal vacancies should they wish to apply. They were also offered the possibility of sessional paid work. Volunteers who wanted to gain qualifications were able to receive support from the team leaders and volunteer coordinators with regards to applications and interviews. Lastly, through partnership work with Stockton Riverside College, volunteers could explore opportunities for funded courses and apprenticeships.

In addition, incentives for volunteers were provided in the form of time banking. Volunteers were given time bank cards to record volunteering hours and once an agreed number of hours was completed, volunteers were eligible to receive vouchers for day trips, leisure activities and others. A catalogue was produced in which all incentives were documented. Whilst an effort was made for a variety of activities to be included in the catalogue, family-related activities were given preference. It was felt that this would attract parents to volunteering, increase health related family activities and improve employment rates for parents (Butler, 2015).

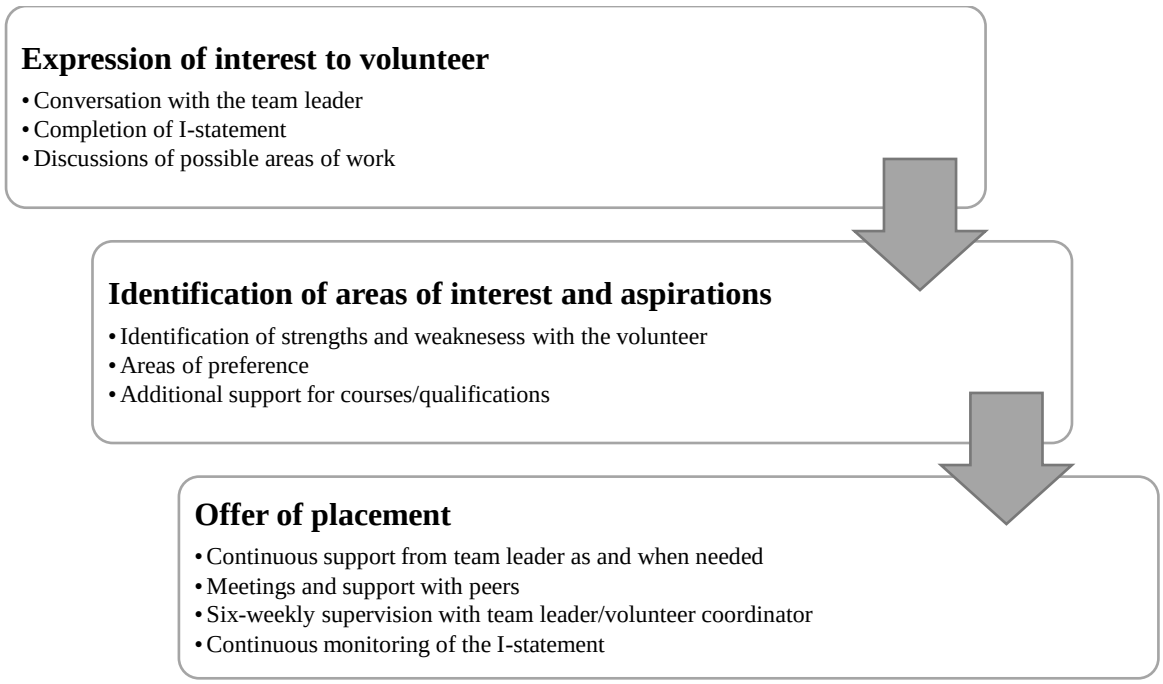
It would be helpful at this point to visually illustrate the way in which the management structure of the programme would work. Figure 4.3. outlines the infrastructure of the FSVP.

Figure 4.3.: Management structure of the FSVP



In addition, the journey that volunteers would follow presented as a process may be helpful to understand how the programme was designed. Figure 4.4. presents this process.

Figure 4.4.: The journey of the volunteer



4.5.5. Outcomes

In addition to the overarching outcomes of the programme which were presented earlier, the programme was measured against certain targets. These were that volunteers would engage with 300 children (0-3 years old) annually; would recruit and train 40 volunteers in the first year, with a minimum of 100 people benefitting from volunteering over the duration of the 3 years of the programme; and would sign up 10 supporting businesses in the first year, with a minimum of 30 over the three years (Butler, 2015).

An outcomes framework was developed around specific key areas, as identified in the service specification of the volunteer programme. More specifically, the programme would ensure that more parents accessed services during pregnancy, post-partum and until their child reached school age. In addition, it would provide children a better and fairer start in life as measured by School Readiness at 5 years of age as well as improve the three key outcomes: cognitive, social and emotional development, speech, language and nutrition (Butler, 2015).

Additionally, the programme would support volunteers in recognising their own worth and the important role they play in their communities regarding health promotion, by supporting individuals and families within their own community. It would also increase understanding and knowledge of pregnancy and early years issues amongst local residents and communities. This would lead local residents to improve and make positive changes in the lives of children. The programme would also put mechanisms in place through which residents could influence how services are developed in their area as well as take an active role in their communities. Lastly, the programme would ensure that "hard to reach" communities engage with services (Butler, 2015). The outcomes framework therefore was developed against these areas.

4.5.6. Evaluation and review of the programme

The programme's internal evaluation and review was part of its design and was used both as a monitoring tool for commissioners and as a tool that would allow adaptation and change as needed. The Impact and Evaluation Toolkit was utilised, to support practitioners to design and implement evaluations (Butler, 2015). The toolkit provides a framework for monitoring and evaluating services based on a three-stage circular process; plan and deliver, evaluate and review; and measure impact.

This process allowed for a variety of monitoring and review processes. Whilst individual case files were reviewed on a monthly basis, the activities and events delivered were reviewed on a quarterly basis. Quarterly reports were used to show the process and progress from initial contact of families with the children's centre, to case specific outcomes (such as improvements in quality of life), to service specific outcomes and key performance indicators. Finally, an annual quality audit which measured the programme's impact, taking into account service users' feedback as well as stakeholders, was produced in order to illustrate the high quality of the service (Butler, 2015).

Additionally, the programme used a participation model to ensure that children, young people and families had the opportunity to feedback, evaluate and shape the programme and the way it was delivered. Due to the fact that the emphasis of the programme from the outset was on engaging with the "hard to reach" families, people who did not engage with children's centres, services were consulted and their feedback was used to shape the programme. By using outreach work, street based consultation and workshops, the programme ensured that the views of those who were not comfortable attending services were also gathered (Butler, 2015).

This concludes the description of the FSVP. The section presented what the programme set out to achieve and how it hoped to achieve it both in terms of support for the families and the community as well as the support for volunteers. Due to the fact that this description was largely based on the outline of the programme's commissioning contract and is therefore not necessarily academic, it is essential to describe the programme and its main actors (i.e. the volunteers) using a research-based framework. Such a framework will help frame a practice based programme in a detailed, structured way so that it can be examined for its merits and flaws systematically (South, Meah, Bagnall and Jones, 2013). The same framework that has been used in the next section to frame the programme at its inception, is later in the thesis (section 6.3) used again to illustrate how the programme evolved and changed over time and what it looked like by the end of its three-year course.

4.6. Descriptive framework

There are many frameworks used to describe public health interventions and how they work or are meant to work (Fischer, et al., 2013). However, the majority of existing and widely accepted frameworks tend to focus on the description of structured interventions, and normally using a positivist method (i.e. how many people are receiving the intervention, what dosage the intervention group are expected to receive and how often etc.) (Fischer, et al., 2013). Fewer frameworks exist to describe initiatives or community interventions such as the FSVP that follow a less structured format.

In addition, as South et al. (2013) point out, there is a lack of descriptive frameworks, particularly around interventions which utilise "lay health workers". Lay health workers are defined as people with no previous qualifications in public health who receive training in health and early years subjects and are expected to support and provide advice (South, Meah, Bagnall and Jones, 2013). The volunteers in this programme fall under this definition. Although it is

acknowledged that there is a wider debate around the terminology of volunteering and the term "volunteer", for the purposes of this study the terms lay health workers and volunteers are considered synonymous.

South et al. (2013) created a framework to increase clarity around public health interventions that use volunteers (South et al., 2013). The framework was designed to be descriptive and is divided into four dimensions; the intervention dimension, the volunteer role dimension, the service dimension and the community dimension. Using a framework which encapsulates all the different elements of the intervention as well as the roles of volunteers, the support received and the support provided to the community, can draw out the complexities of such interventions, unify the evidence base and identify best practice examples that can be replicated in different settings (South, et al., 2013). Adapted from South et al.'s (2013) paper, I applied the framework to FSVP as presented in Table 4.1.:

Table 4.1.: South et al. (2013) descriptive framework applied to the volunteer programme

Intervention dimension		**Role dimension**		**Service dimension**		**Community dimension**	
Health issue(s)	Child development, speech, language and nutrition- overarching aim to improve school readiness	**Primary role/ function**	Two types: family champions providing targeted support to families and community heroes raising awareness in the community Peer support and community development were primary functions of the volunteers	**Training & development**	The training for both types of volunteers focused on both preparing them to deliver elements of the programme and developing them personally as individuals	**Lay (community) designation**	All volunteers were expected to be local to Stockton Town Centre; all types of volunteers were required, non-professionals, peers to recipients and embedded in the community
Horizontal or vertical programme	Vertical programme in that it addresses numerous issues through health promotion	**Core and subsidiary responsibilities/ tasks**	Family Champions: conduct visits to engage with families, provide advice and befriending support, work alongside professionals to facilitate engagement, signpost and refer to services Community Heroes: organise pop up events to engage with the community, facilitate registration with the children's centres, organise activities around child development, speech language and nutrition, raise awareness through local businesses	**Payment**	Volunteers received vouchers and access to family based activities once they completed an agreed amount of hours	**Accountability**	Professionals identify volunteers. Volunteers giving access to community for professionals as well as working with it
Community of interest (target population)	Pregnant women, children 0-3 years old and their families but also the community as a whole	**Expertise sought**	Experiential, embodied, cultural and linguistic	**Extent of autonomy**	All volunteers were expected to work alongside professionals whether health, social care or early years professionals	**Social networks**	Volunteers using both their existing social networks but also develop new ones to reach the "hard to reach"
Intervention method(s)	Two methods of support: through community enhancement and health promotion and through targeted support for those who need it	**Mode of working**	All volunteers worked with individuals, groups and the wider community the community				
Setting	Community based particularly around children's centres						
Delivery organisation (sector)	Voluntary, Community and Social Enterprise Sector (Big Life Families)						

As South et al. (2013) acknowledge, this framework is as comprehensive as possible without being exhaustive of all roles, responsibilities or aspects of volunteer work within an intervention. It does provide, however, a useful way of organising and presenting the distinct dimensions of an intervention which utilises volunteers.

Applying the framework onto the FSVP showed that in its inception, the programme aimed to cover all aspects of community and early years work utilising different types of volunteers for different purposes. Despite the distinction between the volunteer roles in terms of targeted support or community engagement, the majority of other dimensions were similar for both types of volunteers. The training, incentives and level of autonomy were the same, regardless of volunteer roles, as were the characteristics needed for volunteers, accountabilities and social networks to be utilised.

Beyond that, the framework provides a clear description of the programme's initial overall design. However, it does not outline (nor was it intended to) the mechanisms by which the outcomes would be achieved, why certain activities were chosen over others, why the different types of volunteers were needed and how, having different types of volunteers would aid the programme fulfil its purpose. For this, a theory of change needs to be developed. However, a theory of change was never created by the programme's initiators. For this reason, and in order to present how the programme worked and why, I developed the theory of change and it forms part of the findings of the thesis (Chapter 6, section 6.1).

4.7. Summary

This chapter aimed to present a description of the FSVP in a thorough and fair way using the specification that was developed and written by the programme's executive management. An effort was made to exclude any analytical or personal thoughts, so that the reader can

understand where the programme started. In order to achieve that, a descriptive framework was used which outlined the different dimensions the work of volunteers entailed. The reason for focusing on the volunteer aspect was that part of the focus of this PhD is to look at the concepts of volunteering and volunteers as depicted in literature as well as in personal accounts. Moreover, the use of the framework allows for academics or practitioners developing similar interventions to have a clear understanding of how this programme worked. To this end, and whilst acknowledging that this chapter presented the idea for the volunteer programme, the findings and discussion chapters will illustrate the reality of the programme once implemented.

This description of the case study concludes the introductory chapters of the thesis. The theory, literature and research backgrounds to the thesis have been presented and the case study has been outlined as thoroughly as possible. The next chapter will focus on the methodology, methods and procedures that were used to explore volunteering in the context of community-based approaches.

5. Chapter Five: Methodology

This chapter outlines the ontology, epistemology, methodology and methods that were employed for this study. It begins with the background to the study which largely influenced the approach that was used to achieve the aim and answer the research questions. The different scientific paradigms are introduced followed by the epistemological stance of the researcher, putting the researcher in the context of the research. Following this, the study design is described, including the methodological approach that was adopted and the specific methods that were used. This is followed by a description of the recruitment and data collection methods. Lastly, the ways in which the data were analysed are presented. The chapter ends with a brief summary.

5.1. Background

This study, similarly to many PhD level studies, was influenced by a number of factors and it evolved considerably over the years. In 2015, Teesside University's School of Health and Social Care won a grant to evaluate A Fairer Start (AFS), the early years public health initiative outlined in Chapter Four. The commissioners of the evaluation were keen to have a PhD level study run alongside the evaluation. For this reason, the evaluation and the PhD were, initially, conducted together. It was thought that the data collected as part of the evaluation would inform the PhD study. The initial research design involved a mixed methods systematic review on the evidence base for the effectiveness of early years interventions which have used volunteers for child development and nutrition. The protocol for this systematic review was published (Machaira, Azevedo, Hamilton, Ells, Lingam and Shucksmith, 2016). In addition to the systematic review, there was a plan that a quasi-experimental study would be conducted to assess the effectiveness of AFS over the years. Lastly, a qualitative process evaluation would take place to explore the intricacies of AFS, the extent to which its implementation was

successful and the impact that it had on stakeholders. This research design was part of the grant proposal and I, the PhD researcher, had no involvement in writing it. Once the bid was successful, an advert for a full time studentship was published, I interviewed for the position and was successful. Approximately six months after starting work on the evaluation/PhD, it became apparent that the quasi experiment initially designed would be unfeasible. The reason was, as outlined in the previous chapter, the AFS intervention changed considerably, given that there were no specific activities being provided to certain groups and therefore any comparisons between groups of children would not be appropriate. As AFS evolved from an intervention to an ethos, any quantitative measurement of its success would be inaccurate. Therefore, the outcomes that were initially set out could not be measured. The quasi experiment therefore was removed from the research design and the study continued with a large-scale qualitative process evaluation which I was instrumental in designing.

Following the completion of the first year of the PhD, and during my progression board, which was attended by an external and an internal examiner, it was felt that the evaluation and the PhD should be separated for two reasons. Firstly, the implementation of AFS was delayed and its goalposts and desired outcomes were changed (in fact, in a state of fairly constant flux), which could have been detrimental for the PhD. Secondly, exploring both the systems change element of AFS and the FSVP would have been unachievable for a PhD level study with two remaining years of study. The plethora of information and data would have meant that I would not have been able to explore both elements in the depth required for a PhD. For this reason, I decided to focus on the volunteer programme, as volunteering is a subject that has always taken my interest (as mentioned in Chapter 1, section 1.3). Given that I subscribe to the interpretivist paradigm (as will be explained further in section 5.3), a qualitative case study approach was adopted. With regards to the systematic review, it was felt that the quantitative element would not fit in the qualitative design of this thesis and therefore was abandoned. The qualitative

element of the review was pursued. A search strategy was developed and abstract and titles were selected for full text screening. However, after careful examination by me and my main supervisor the full texts were deemed inappropriate for data extraction and the systematic review was not completed. Five papers were identified for inclusion but they were deemed inappropriate based on the quality of evidence reported. One paper (Watt, et al., 2014) was methodological and did not report any qualitative findings. Robinson, VandeVusse and Foster's (2016) paper reported on the experiences of women who have had breastfeeding peer support from other mothers but their sample was recruited from the peer supporters and therefore was heavily biased towards peer support, thus constituting their findings less reliable. Similarly, Meier et al.'s (2007) paper reported favourable findings towards peer supporters but participants were recruited through the peer supporters and therefore the findings are unreliable. Halpern and Larner's (1987) paper did not report any qualitative data or quotes from participants. Lastly, Rios-Ellis et al.'s (2015) reported qualitative findings but peer supporters were present during interviews thus compromising the integrity of the results. Due to the poor quality of papers, it was decided to abandon the review. Therefore, the study presented in the thesis is an intrinsic, qualitative case study.

Due to the fact that the evaluation of AFS continued to run alongside the PhD, I ensured that my materials were constructed in such a way that I could use the data for both purposes. All participants were aware that the information they provided would be used for both the evaluation of AFS and the PhD and ethical approval was sought both for the evaluation (Study No 148/15) and the secondary data analysis (Study No R149/18) I performed for the PhD.

It was essential to briefly present the background of the PhD as it largely influenced the final research and this thesis. Given this background, I decided that case study methodology was the

most appropriate to adopt in order to explore volunteering within public health, community-centred approaches in depth. The reasons for this are outlined in the following sections.

5.2. Aim and research questions

The aim of this study was to explore what volunteering is and how it works in a community-centred volunteer programme, through examining professionals', volunteers' and parents' accounts. More specifically, it aimed to answer questions on two major topics; volunteering and community-centred volunteer programmes. The research questions on volunteering were:

1. How is volunteering understood in the context of a community-centred public health programme?

2. What elements influence volunteering in the context of a community-centred public health programme?

The research questions focussing on community-centred programmes were:

3. How is a community-centred public health programme expected to influence change within a community?

4. In what ways does a community-centred public health programme influence stakeholders working within and participating in it?

5.3. Ontology, epistemology and context

Every researcher, and arguably every individual, views the world through certain philosophical lens that provide clarity with regards to what reality is and how knowledge is acquired (Scotland, 2012). In research terms, this philosophical lens can be understood as paradigms. Paradigms are the sets of beliefs, thoughts and opinions on the world and consist of four

components: ontology, epistemology, methodology and methods. Ontology is the study of being and it is concerned with questions around reality; how do people know what exists, what is real and what is not (Crotty, 2014; Scotland, 2012). Epistemology is concerned with questions around knowledge; how do people know what they know. Based on the philosophical assumptions that inform these ontological and epistemological positions, one forms an idea of how they can go about investigating and solving problems (Crotty, 2014). This idea is the methodology and the subsequent methods that one uses in order to explore a certain subject.

In social research there are two main paradigms; positivism and interpretivism. In the positivist paradigm, the underlying ontological assumptions are that an objective reality exists (Creswell, 2013). The epistemological stance is that of objectivism; meaning and knowledge can be acquired since reality is objective. Methodologically, positivists aim to explain relationships and uncover causes which influence outcomes which can then be generalised. Deductive approaches are used, whereby a hypothesis is developed based on a theory and then facts are sought to confirm or reject it. Experimental research designs are predominantly used, quantitative data are collected and statistical methods are used to analyse them (Scotland, 2012).

In contrast to positivists, interpretivists hold the ontological position of relativism, which posits that reality is subjective (Creswell, 2013). Epistemologically, interpretivists believe that meaning and knowledge is constructed by each individual as they experience a phenomenon. People may understand the same object or phenomenon differently, thereby creating their own reality and knowledge around it. Therefore, interpretivist methodologies aim to understand a phenomenon from the point of view of the individual who experienced it. Inductive approaches are used, whereby a researcher makes no assumptions about a phenomenon beforehand; theories are derived from the data which are grounded in the experiences of individuals. Several

types of research design employ this stance: e.g. case study, ethnography, phenomenology (Scotland, 2012).

5.3.1. The researcher

For detailed research, it is imperative that the researcher's own ontological and epistemological assumptions are acknowledged, as they influence the methodology and methods. I subscribe to the interpretivist paradigm as I believe that reality and meaning are constructed and an objective reality does not exist in the context of social constructs such as community, volunteering or the way an illness is experienced. I believe that reality is formed based on individuals' experiences, views, opinions, preconceptions and cultural influences. Although I appreciate the usefulness of the positivist paradigm and its contribution to science (medicine, physics, epidemiology etc.) I reject the notion that everything can be measured quantitatively. For example, it is a fact that HIV causes AIDS and it was the positivist paradigm that led to the discovery of that fact: however, I believe that AIDS as a disease can be experienced by individuals in different ways. For example, the social consequences of AIDS may depend on the social constructs that the individual lives in. Questions around these meanings and the way in which such phenomena are understood, can be best answered by individuals themselves. Therefore, this study was designed based on these assumptions and with the view to elicit the voices of individuals (participants).

5.4. The study design: case study

Based on the interpretivist paradigm which I subscribe to, qualitative methodology was adopted for this study. More specifically, a qualitative case study research design was used which allowed for in-depth exploration of volunteering in the specific context of the volunteer programme as a community-centred approach.

Case study research is an exploration and analysis of a single case which aims to capture and understand the complexity of the case under investigation (Yin, 2003). Some have argued that case study is not a methodology in itself; it is a way to understand what needs to be studied (Creswell, 2013). However, many have asserted that it is a methodology, as it pursues a strategy in collecting and analysing data in order to explore, describe and understand a bounded system (a case) (Stake, 1995). Case study in qualitative research is the study of a bounded system or systems over time which involves the gathering of in depth data from multiple sources (observations, documents, interviews, focus groups) with the purpose of the thorough description of the case under investigation (Merriam, 1988).

There are three main types of case study approaches; the single instrumental case study, the collective case study and the intrinsic case study (Yin, 2003). The single instrumental case study refers to the in depth study of one issue through a bounded system in which the issue is present. The collective case study is similar but the researcher studies the issue through multiple bounded systems in an attempt to show different perspectives on the issue. Lastly, in the intrinsic case study the researcher focusses on the case itself (a programme or activity for example) because the case presents a uniqueness or novelty (Creswell, 2013).

The procedure that needs to be followed when a case study methodology is adopted involves a number of steps (Yin, 2003). Firstly, the researcher needs to decide whether the methodology is appropriate. Case study methodology is appropriate when a bounded system can be clearly defined and there is a need to study the case in depth in order to illustrate the problem or phenomenon of interest (Yin, 2003). As explained in the fourth chapter, the volunteer programme that is the focus of this PhD provides a clearly defined bounded system as it was a pilot programme implemented in a clearly defined geographical area with a certain number of people taking part in it. In addition, the volunteer programme, in the way it was commissioned

and implemented, was novel in the area, thus presenting a unique opportunity to study it over the three years of its implementation. Therefore, case study methodology was the appropriate methodology to adopt.

The second step in the case study approach is to identify the case and decide on the type of case study methodology that will be adopted (Stake, 1995; Yin, 2003). It was decided that an intrinsic case study design was the most appropriate to employ. This was because, in accordance with the aim of the PhD, in order to understand what volunteering is and how it works in the context of a volunteer programme as part of a community-centred approach, the focus of the study needs to be on the case (i.e. the volunteer programme) rather than the issue (i.e. volunteering). In order to answer the research questions around how this particular volunteer programme was expected to work, the elements that influenced it and the perceived impact that it had on its stakeholders, the case study needed to focus on the programme. Therefore, an intrinsic case study was conducted.

The next step in conducting an intrinsic case study is to decide on what data will be collected and what sources of information will be used to explore the study in depth (Yin, 2003). Case study experts suggest that six types of data should be collected: documents, archival records, interviews/focus groups, physical artefacts, direct and participant observations. This list of types of data is neither exhaustive nor compulsory; the researcher needs to decide what types of data are appropriate for the study (Yin, 2003). As outlined in the next section, the data collected for this case study were observations, documents and participant accounts.

5.5. Data collection

5.5.1. Observations

As part of the data collection for this study, I was present during implementation group meetings and engagement events organised by the commissioners of the FSVP. During these observations, I was able to see the way professionals interacted with each other, as well as volunteers, and how commissioners interacted with professionals and volunteers. In addition, I was present during stay and play sessions organised by the managers of the FSVP where parents and volunteers interacted. With regards to the questions that the observations aimed to answer, these were primarily general - scoping in nature - and around the level and extent of engagement shown by different groups of people (commissioners, professionals, volunteers and parents) during these events (Thomas, 2003).

Following the ethical approval for the study, no names were recorded during these observations; field notes were taken immediately after and involved information on how engaged people appeared to be, what discussions took place with regards to the FSVP and how it was perceived by different people according to the views they expressed during the observations. All people observed were aware of my presence. Table 5.1 outlines all the events, sessions and meetings I attended as part of this study.

Table 5.1.: Events, sessions and meetings attended

Event/session	**Dates**	**Duration of each individual contact**	**Purpose**
Operations group meeting	30/06/15 29/09/15	2 hours	To understand AFS and the FSVP, to familiarise myself with key stakeholders, to explore and be alerted to the intricacies of implementation
Data, tracking and monitoring task/finish group meeting	25/06/15 21/07/15	2 hours	To understand what data was collected as part of AFS and the FSVP, to provide guidance as needed
Meeting with FSVP leaders	02/07/15	2 hours	To understand the FSVP, what it aimed to achieve and how, to familiarise myself with stakeholders, to understand how volunteers would be used
Networking event	03/03/16	4 hours	To understand how AFS and FSVP fit together, to familiarise myself with stakeholders, to see the work completed to date and the way forward
Children's centre sessions	29/05/17 05/06/17 12/06/17 19/06/17 28/06/17 03/07/17 10/07/17	4 hours	To see how the FSVP worked on the ground, to understand the roles of volunteers, to see how volunteers worked with professionals and families
Project team meetings	11/04/17 19/07/17	2 hours	To understand how AFS and FSVP were implemented, to understand the blockages, to agree evaluative activities, report on progress and findings
Meetings with strategic stakeholders	11/05/15 25/01/16 23/03/17 24/03/17 29/03/17 27/04/18	2 hours	To discuss interim findings, understand intricacies and discuss the future of the evaluation
Meeting with project officers	28/05/15 16/12/15 18/02/16 01/04/16 28/10/16 24/02/17	2 hours	To understand AFS, monitor progress, understand arising issues

Observations were a useful way of immersing into the programme and familiarising myself with the many actors within it. However, observations were only ~~be~~ used to alert me to any obvious issues that I could explore further during interviews and focus groups. In order to ensure that a full picture of the FSVP could be formed, the data collection method of observations was supplemented by document analysis.

5.5.2. Documents

Studying and analysing documents is an integral part of data collection and analysis for an intrinsic case study (Stake, 1995). Studying documents has the advantage of collecting information that would not be accessible any other way. For example, some people may not feel comfortable taking part in an interview or focus group or may provide certain answers because they know they are being researched. In addition, document analysis mediates the "researcher effect", thus minimising the influence of the researcher on the research (Thomas, 2003).

For this PhD an important document was analysed. The commissioners' document, which outlined the FSVP, was obtained which included the successful bid from the managers of the volunteer programme (Butler, 2015). In this document the programme was described in depth, including its aims, objectives and deliverables. Similar to observations, document analysis has limitations that were acknowledged throughout the analytical process. Although documents can have a level of objectivity that interviews and focus groups lack, they are subjective accounts. In addition, document analysis is entirely dependent on the quality of the documents included. Lastly, and particularly relevant to this study, documents are not adaptable to change; the outcomes that a commissioning contract set out three years ago, may not be relevant three years later as a programme evolves and changes through time (Stake, 1995). The best way of capturing such information is through discussions with stakeholders involved at different time points.

5.5.3. Interviews and focus groups

Data collection through interviews and focus groups is the most common method used in qualitative research (Crotty, 2014). Speaking to participants directly provides the researcher

with rich accounts of their views, opinions and experiences of the phenomenon under investigation. In case study methodology, conducting interviews and focus groups is vital in order to understand and describe the case thoroughly (Bryman, 2016). By using interviews and focus groups, the researcher can explore the case by becoming part of it, by developing relationships and rapport with participants, thus understanding them better. This allows participants to be honest about their experiences, views and opinions about the phenomenon in question (Bryman, 2016; Mason, 2007). Indeed, acknowledging individual experiences and understanding that a phenomenon can be explained through the person who has experienced it is central to the philosophy of interpretivism (Berg & Lune, 2014; Walliman, 2005). By realising this philosophy and accepting that the truth about a phenomenon is subjective and dependent on preconceptions and beliefs, both individual and collective, the researcher can take individuals' accounts of the phenomenon, immerse oneself in the data and provide interpretations of these accounts (Silverman, 2013; Walliman, 2005).

In this PhD study, and in accordance with the case study methodology, the perspectives of those who were involved in the volunteer programme were pivotal in understanding and presenting the FSVP as a case study.

5.5.4. Interview and focus groups schedules

In accordance with most qualitative studies, the interview schedules for this PhD were semi-structured (Walliman, 2005; Mason, 2007; Berg & Lune, 2014; Bryman, 2016). In addition, following the qualitative case study methodology approach which is a data driven, inductive approach to research, no preconceived theoretical framework was used to inform the development of the interview schedules. The questions were broad in order to capture participants' perspectives on volunteering and their level of engagement with the programme.

It was anticipated that participants would have different perspectives depending on their status (strategic professionals, frontline professionals, volunteers, mothers) and therefore the interview schedules were adapted to account for these perspectives. The table below presents the questions that were asked during the interviews/focus groups with each group of participants.

Table 5.2: Interview/focus group questions

Participant Group	**Questions**
Professionals	What are your thoughts on volunteering in general? What are your thoughts on the volunteer programme in particular? Have you engaged with it? If yes, what did that engagement involve? Were you happy with the support you received? If no, why have you not engaged? Do you think a volunteer could help you in your day-to-day job?
Volunteers	What are your thoughts on volunteering in general? Describe your experiences of being part of the volunteer programme. Have you worked with families? Practitioners? Team leaders of the programme? What training have you received and what are your thoughts on that? Could anything have been done differently? If so what?
Mothers	What are your thoughts on volunteering in general? What are your thoughts on the volunteer programme? What support have you received from the volunteer programme?

These interview/focus group schedules were merely a guide and resulted in rich conversations about volunteering in general, as well as specifically within this case study. In addition, these schedules allowed me to explore important matters discussed by participants. The interview schedules were piloted with five strategic stakeholders and their broad nature was found useful

for participants to be able to elaborate on points they felt were important. Although the interview schedules were not piloted with volunteers or mothers, due to recruitment issues (see section below), the schedules were broad enough to allow for rich conversations with both groups and no alterations needed to be made during the interview process.

5.6. Recruitment and procedure

The previous section detailed the methodology that was adopted and the data that were included in the case study. This section focusses on the recruitment strategy and ethics that underpinned the study and the participants for the interviews and focus groups. It was acknowledged from the very beginning that the volunteer programme would change and evolve through time. It was therefore decided that data would be collected at various time points to reflect the evolution of the case study. Data collection was therefore conducted in four phases; the scoping phase, the pre-implementation phase, the implementation phase and the post-implementation phase.

5.6.1. Sampling strategy and procedure

In accordance with case study methodology and due to the fact that only individuals involved in the volunteer programme would be able to provide meaningful data for this study, purposive sampling strategies were employed (Ritchie, Lewis, Nicholls, and Ormston, 2013). Although purposive sampling is not uncommon in qualitative methodologies, there was a need to ensure the fair and equitable inclusion of all participants that could offer informed accounts. For this reason, all strategic stakeholders involved in the development and implementation of the programme were invited to take part in the study. Similarly, all professionals and volunteers who worked within the boundaries of the programme and were involved in its delivery received study invitations.

More specifically, strategic stakeholders and early years professionals as identified by Catalyst, were sent invitation letters, participant information sheets and consent forms (Appendices A, B and C). Volunteers also received the same materials from the managers of the FSVP. Participants were provided with my contact details and contacted me directly to arrange an interview. In the cases where participants contacted Catalyst expressing their willingness to participate, Catalyst provided me participants' contact details to arrange an interview.

With regards to parents, information about the study was displayed at children's centres with my contact details (Appendices D and E). In addition, I made an effort to be present at regular sessions within children's centres in order to answer any questions and provide more information about the study for parents who were interested in taking part. Verbal and written consent was sought from all participating parents (Appendix F). Thus, and despite the fact that the methodology limited me to a purposive sample, an effort was made to ensure that the views of as many individuals as possible were gathered. All interviews and focus groups were carried out at the participants' preferred location (place of work, children's centre) and informed consent was obtained from participants before their participation. Interviews and focus groups were audio recorded and lasted between 15-75 minutes. All interviews and focus groups were transcribed by an external professional transcriber. Upon receiving the transcribed interviews/focus groups I read them in conjunction with the recordings to ensure their accuracy. Transcripts were not returned to participants for their comments due to time constraints.

With regards to obtaining the document which was included in the analysis, an email was sent to both Catalyst and BLF to request it (Appendix G) along with an information sheet detailing the reasons why it was needed (Appendix H). Consent forms were sent to both organisations in order to ensure they were happy for the document to be included (Appendix I).

5.6.2. Ethics and ethical challenges

The evaluation of AFS received ethics committee approval through Teesside University Ethics Committee (Study No 148/15) (Appendix J). The secondary data analysis for the purposes of the PhD received approval through Teesside University Ethics Committee (Study No R149/18) (Appendix K).

It is important at this point, to outline and discuss the ethical challenges that arose during this PhD. I will describe four key challenges and the ways I addressed each of them below.

Challenge 1: *Participant recruitment*

The first challenge was around participant recruitment. Working with gatekeepers who are responsible for participant recruitment has been debated in the literature due to the potential for a biased sample, whereby gatekeepers invite certain individuals to participate in the study to ensure positive findings (Crotty, 2014). Participant recruitment needed to be conducted through Catalyst and Big Life Families, because they had knowledge of who was taking part in the FSVP and had access to their personal information, including email addresses and phone numbers. In accordance with the ethical approval from Teesside University, I could not have access to identifiable characteristics of participants. Therefore, the only way that recruitment could go ahead was through Catalyst and Big Life Families. As McAreavey and Das (2013) suggest, when gatekeepers are used in participant recruitment, an evaluation of their motives needs to take place by the researcher. Given that Catalyst and the CCG devoted a large amount of money for the evaluation of AFS and the PhD, I felt that they wanted to make sure that a thorough evaluation is conducted and I did not feel that there was a reason to suspect that they would hinder or influence participant recruitment to get desirable findings. However, the potential risk of gatekeepers influencing recruitment was identified and steps were taken to

ensure that the sample was as inclusive as possible. To mitigate for potential bias in recruitment, all professionals and volunteers who were involved in the programme were invited to participate in the study. The invitation letters and participant information sheets urged potential participants to contact the researcher directly to discuss their participation rather than the gatekeepers and emphasised that their participation (or refusal to participate) would remain confidential. Lastly, before every interview/focus group, verbal as well as written consent to participate was sought by the researcher emphasising that participation is voluntary and confidential.

Challenge 2: *Confidentiality and anonymity*

The second ethical challenge that needed to be taken into account was around confidentiality and anonymity. The fact that AFS and the FSVP were small-scale initiatives with a relatively small numbers of actors within them meant that there was an ethical issue around whether confidentiality and anonymity of participants could be maintained during the reporting phases of the evaluation and the PhD. Given that, the professionals who worked within AFS and the FSVP knew each other, it would have been possible for someone reading the evaluation report to identify who the participant was whose quote was used to illustrate a theme. This was mitigated through a number of different ways. Firstly, all participant information sheets included a statement which informed them that anonymity could not be guaranteed due to the relatively small number of participants. This ensured that participants were aware of this risk before agreeing to take part in the study. All participants were also reminded of this before the start of an interview or focus group and they had an opportunity to withdraw at that point. In addition, I ensured that any reports that I wrote as part of the evaluation of AFS and the PhD included vague job roles (i.e. early years professional, strategic stakeholder) rather than specific roles which could identify participants.

Challenge 3: *Developing trust*

The third challenge was around developing trust. Minkler (2004) argued that there are inherent power tensions that can exist between a researcher (outsider) and participants (insiders). An ethical challenge therefore was around developing trust with commissioners, volunteers and parents. In order to ensure that these stakeholders trusted me and did not feel that I was an outsider studying/judging them, I tried to have a presence throughout the implementation and delivery of AFS and the FSVP. As described earlier in this chapter, I attended strategic stakeholders' meetings, task and finish groups etc. This gave me an opportunity to get to know potential participants and more importantly, it gave them an opportunity to get to know me and understand the scope of my work. Similarly, I attended children's centres sessions which allowed me to get to know volunteers as well as parents and gave them an opportunity to know me and ask questions. This strategy facilitated recruitment and addressed the challenge of developing trust as an outsider.

Challenge 4: *Negotiating and maintaining boundaries*

The last and equally important challenge was around negotiating boundaries and maintaining a professional relationship with commissioners. The changes in AFS and the FSVP meant that commissioners were unsure how to proceed as far as the evaluation was concerned. This led to them changing their minds as to the way the evaluation was to be conducted in terms of my role as a researcher and their role as commissioners. More specifically, when commissioners felt that participant numbers were low, they contacted me to try and obtain information about participants who had refused to be interviewed. Generally, they tried to overstep the boundaries of my independent role as a researcher, the trust I had developed with and the confidentiality I had promised to the participants in my study.

Although this challenge was not one that I had thought about and mitigated against from the beginning, I dealt with it using my knowledge around ethics and with support from my supervisory team. I explained to the commissioners that I have to abide by certain rules, particularly around confidentiality of participants. I also explained that their involvement in trying to identify who participated in the evaluation and who did not would damage the evaluation by compromising my role as an independent researcher. When needed, I referred commissioners to my, then, Director of Studies so that she could explain further. Once commissioners understood the ethical processes and procedures that I had to operate within, they understood that their requests could not be fulfilled and the situation was resolved.

Even though this account of the ethical challenges may be perceived as negative towards commissioners, this is not its purpose. Its purpose is to present the challenges of working within an environment of conflicting interests. It is perfectly understandable that commissioners of any research or evaluation want their project/initiative/service to be successful and effective given their investment. It is also perfectly understandable that people who have not had experience or knowledge of research and its processes were unaware of the ethical rules to which a researcher has to adhere. As much as conducting an evaluation and a PhD simultaneously and for the same project was a learning curve for me, the researcher, it was equally a learning curve for the commissioners.

5.6.3. Participants

Data collection took place in four phases. In August and September 2015, one scoping interview and two focus groups with strategic stakeholders took place in order to explore the initial stages of the volunteer programme. In August and September of 2016, the next phase of data collection took place. Strategic stakeholders - professionals that were involved in the

conception, design and management of the volunteer programme - were invited to take part in the study. Invitations were sent to 22 people and 14 agreed to be interviewed.

The ~~last~~ third phase of data collection began in May 2017 and finished in October 2017. Frontline workforce staff were invited to take part in a face-to-face or telephone interview or a focus group. Seventy-four professionals were invited and twelve agreed to be interviewed. Volunteers and mothers were also invited to interviews or focus groups.

In addition, three more interviews and two focus groups were conducted with strategic stakeholders following the implementation of the programme in order to get an overview of the FSVP from its conception through to its end. In total, 41 interviews and 5 focus groups were conducted. The roles of different participants are presented in Table 5.3. It should be noted that some participants were interviewed more than once over the course of the study and therefore the total number of participants is 44 but the total number of interviews is 46.

Table 5.3.: Participants' roles

Organisations	**Participants**
Stockton Borough Council Public Health	5
Stockton Borough Council Children's Services	9
Catalyst	3
Big Life Families senior management	2
Big Life Families frontline professionals	2
Health professionals (midwifery and health visiting)	5
Children's centres professionals	5
Volunteers	9
Parents	4
Total	**44**

As this table shows, every effort was made to ensure representation from all stakeholders involved in the FSVP including local authority, health, children's services, early years and children's centres professionals as well as volunteers and mothers. In addition, due to the fact that data were collected at multiple time points, it is useful to show when data were collected

and by whom. For this reason, table 5.4. was developed which outlines participants' roles, data collection method and date of data collection.

Table 5.4.: Participants' roles, data collection method and date of data collection

Participant	**Data collection method**	**Date**
Strategic stakeholders (Council children's services)	Scoping focus group/pilot	26/08/15
Strategic stakeholder (BLF)	Scoping interview/pilot	02/09/15
Strategic stakeholders (Catalyst)	Scoping focus group/pilot	11/09/15
Strategic stakeholder (Council children's services)	Interview	01/08/16
Strategic stakeholder (BLF)	Interview	03/08/16
Strategic stakeholder (Catalyst)	Interview	05/08/16
Strategic stakeholder (Council children's services)	Interview	09/08/16
Strategic stakeholder (Council public health)	Interview	09/08/16
Strategic stakeholder (Council children's services)	Interview	11/08/16
Strategic stakeholder (BLF)	Interview	11/08/16
Strategic stakeholder (Council public health)	Interview	16/08/16
Strategic stakeholder (BLF)	Interview	16/08/16
Strategic stakeholder (Health)	Interview	17/08/16
Strategic stakeholder (Catalyst)	Interview	17/08/16
Strategic stakeholder (Council public health)	Interview	18/08/16
Strategic stakeholder (Health)	Interview	23/08/16
Strategic stakeholder (Council children's services)	Interview	14/09/16
Frontline professional (Health)	Interview	04/05/17
Frontline professional (Health)	Interview	05/05/17
Frontline professional (BLF)	Interview	22/05/17
Frontline professional (BLF)	Interview	06/06/17
Frontline professional (BLF)	Interview	06/06/17
Frontline professional (BLF)	Interview	16/06/17
Frontline professional (Council children's services)	Interview	22/06/17
Frontline professional (Children's centres)	Interview	17/07/17
Frontline professionals (Children's centres)	Focus group	31/07/17
Frontline professional (Health)	Interview	01/08/17
Frontline professional (Children's centres)	Interview	02/08/17
Frontline professional (Children's centres)	Interview	08/08/17
Volunteer	Interview	11/06/17
Volunteer	Interview	12/06/17
Volunteer	Interview	12/06/17
Volunteer	Interview	13/06/17
Volunteer	Interview	15/06/17
Volunteer	Interview	19/06/17
Volunteer	Interview	19/06/17
Volunteer	Interview	28/06/17
Volunteer	Interview	13/10/17
Mother	Interview	02/10/17
Mother	Interview	02/10/17
Mother	Interview	09/10/17
Mother	Interview	09/10/17
Strategic stakeholder (Catalyst)	Interview	19/12/17

Strategic stakeholders (Catalyst)	Focus group	19/12/17
Strategic stakeholder (Council children's services)	Interview	16/01/18
Strategic stakeholders (Children's services)	Focus group	25/01/18
Strategic stakeholder (Public health)	Interview	26/01/18

In addition to the job role which was undoubtedly an important characteristic of participants, other characteristics were equally relevant to this study particularly for volunteers and parents. These are outlined in the section below.

5.6.4. Pertinent participant characteristics

Throughout the FSVP's existence approximately 30 volunteers supported and were supported by the programme. Nine of those volunteers took part in this study. Six of the volunteers who were interviewed were asylum seekers in the UK at the time of data collection.

Of the six volunteers who were seeking asylum in the UK, five were Stockton residents and one was a Middlesbrough resident, having been moved from Stockton. The three remaining volunteers who took part in the study were White British residing locally. With regards to gender, eight volunteers were women and one was a man. Eight volunteers were young parents (seven women and the man) and one volunteer was a grandparent. Seven volunteers were unemployed and two had part time jobs at the time. With regards to parents, all four who participated were seeking asylum in the UK at the time of the interviews. All four were mothers and were unemployed. Due to the plethora of personal experiences and the wealth of information gathered by volunteers and mothers, ~~three~~ four short biopics have been developed as a result of the interviews with two asylum seeking volunteers, a British volunteer and a mother. These can be found in Appendix L. In addition, table 5.5. below shows the pertinent participant characteristics.

Table 5.5.: Volunteers' and parents' characteristics

Participant	Gender	Status in the UK	Employment Status
Volunteer	Male	Asylum Seeker	Unemployed
Volunteer	Female	Asylum Seeker	Unemployed
Volunteer	Female	UK national	Unemployed
Volunteer	Female	UK national	Employed
Volunteer	Female	UK national	Employed
Volunteer	Female	Asylum Seeker	Unemployed
Volunteer	Female	Asylum Seeker	Unemployed
Volunteer	Female	Asylum Seeker	Unemployed
Volunteer	Female	Asylum Seeker	Unemployed
Parent	Female	Asylum Seeker	Unemployed
Parent	Female	Asylum Seeker	Unemployed
Parent	Female	Asylum Seeker	Unemployed
Parent	Female	Asylum Seeker	Unemployed

5.6.5. Sample composition

Before moving on to the next section on data analysis, it is necessary to understand how the number of participants influenced the study, particularly in terms of how representative the sample was and thus, how it transferrable the findings are to different contexts. In qualitative research, it has been argued that the ideal sample size is achieved when saturation occurs; in other words, when no new patterns or themes can be identified (Trotter, 2012). In this study saturation was achieved for some populations within the sample but not all of them. Strategic stakeholders were well represented in the study as 14 were interviewed out of 22 who were involved in the FSVP in total. With regards to frontline professionals, 12 were interviewed out of 74, which can be interpreted as a less satisfactory sample size. However, saturation did occur as the themes and patterns identified in the data were consistent.

Similarly, the number of volunteers who were interviewed was representative of the wider volunteer workforce involved in the FSVP. Nine volunteers were interviewed out of a total of

30. It is important to mention that, given that the majority of volunteers in the FSVP were asylum seekers at the time of the interviews, certain barriers may have prevented more volunteers to take part. As Gabriel, Kaczorowski and Berry (2017) suggest, asylum seekers and refugees may face a number of barriers which hinder their participation in research, from communication and language barriers to distrust, fear and suspicion and power imbalances. Given these challenges, the fact that six volunteers who were asylum seekers agreed to take part in the study is a success. Moreover, data saturation occurred in the interviews with volunteers in relation to the FSVP.

On the other hand, and one of the main limitations of the study is the number of parents who participated. Although, and as previously outlined, every effort was made to recruit parents who were part of the FSVP, the final sample consisted of four mothers. This means that the findings around their experiences of the programme, their thoughts around volunteering and their ideas about similar programmes should be interpreted with caution given that they represent four people's accounts.

One reason for the lack of parents' participation in the study was the FSVP itself. As will be shown in following chapters, families' participation in the programme was low throughout its course which meant that there was not a large pool of potential participants (parents) from which the study could have recruited. Therefore, the limited sample of mothers in this study is evidence of the findings reported in later on this study around the lack of engagement of parents in the programme.

Other reasons for the lack of their participation may also be relevant. The issues in recruiting parents in research have been identified in the literature, particularly in recruitment of vulnerable or disadvantaged parents. Mays and Jackson (1991) suggested that lack of trust may be a fundamental factor in the difficulties of recruiting families. In addition, populations that

are deemed "hard to reach" may have had experiences of previous studies or interventions which exploited them or were not beneficial to them and therefore such populations may be suspicious of and disinterested in taking part in studies or interventions (Horowitz, Ladden and Moriarty, 2002). These factors could have influenced the participation of parents in this study and, despite the researcher's best efforts to develop trust, it may not have been possible.

The gender imbalance of the sample should also be unpicked. Although the recruitment strategy targeted both mothers and fathers involved in the FSVP, only mothers participated. This disparity has been observed in qualitative research with families in general. This has been attributed to the unwillingness of men to talk (Price, Jordan, Prior and Parkes, 2010) as well as, lack of trust in the research community (Randolph, Coakley and Shears, 2019). It would be difficult to determine which factors influenced the decision of parents and fathers more specifically not to take part in the study but the fact remains that the sample size was not representative of this population. Therefore, few assertions can be made on the impact of the FSVP on the community in general and parents more specifically. As a result, it would be difficult to determine whether any such assertions can be transferable to a different context even if the design of a programme is similar to the FSVP. However, the findings from strategic stakeholders, frontline professionals and volunteers can be considered representative of these populations and therefore may be transferable to similar contexts within community-centred approaches.

5.7. Data analysis

Qualitative case study researchers have previously emphasised the lack of clarity of the analytical processes involved in case studies (Miles and Huberman, 1994). This section

provides a thorough description of the processes that were followed for this case study in order to compare and synthesise evidence from multiple sources.

5.7.1. Analytical framework

The analytical framework that was used to analyse the data was proposed by Houghton et al (2015). In their paper, they used a qualitative case study to illustrate how Miles and Huberman's (1994) analytical strategies combined with principles by Morse (1994) can provide a useful, comprehensive and rigorous framework for data analysis in qualitative case studies (Houghton, Murphy, Shaw, & Casey, 2015; Miles & Huberman, 1994; Morse, 1994).

Morse (1994) proposed four principles for qualitative data analysis: comprehending, synthesising, theorising and recontextualising. She argued that these are not methods-specific, they are rather principles that all qualitative researchers follow in order to familiarise themselves with the data, understand them, synthesise and conceptualise them and ultimately provide the context for them (Morse, 1994). Although this is a helpful way of understanding qualitative data analysis, it fails to provide specific techniques or skills that are to be utilised in order to perform the analysis (Houghton et al., 2015).

Miles and Huberman (1994) developed data analysis strategies that provide more detail on what a researcher needs to do in order to conduct a thorough analysis of the data collected as part of a case study. The strategies proposed have been influential in case study research and have successfully been used in previous case studies. Houghton et al. (2015) proposed a framework that utilises the four principles for qualitative data analysis (Morse, 1994) and incorporates the strategies for case study data analysis (Miles and Huberman, 1994). The table below illustrates the framework.

Table 5.6: Analytical Framework adapted from Houghton et al. (2015)

Stages of analysis	**Analysis strategies**	**Purpose**
Comprehending	Broad coding	General accounting scheme that is not specific to content but points to the general domains in which codes can be developed inductively.
Synthesising	Pattern coding Memoing	Explanatory, inferential codes to create more meaningful analysis.
Theorising	Distilling and ordering	Memos tie together different pieces of data into a recognisable group of concepts.
Recontextualising	Developing propositions	Formalise and systemise into a coherent set of explanations.

This framework is particularly useful as a guide to analysis because it provides a clear and robust way of understanding and synthesising data from multiple sources. In addition, it guides the development of concepts and the recontextualisation of the data in order to describe the case study. The specific processes that have to take place are described in the next section.

5.7.2. Analytical processes

The analytical process begins with comprehending the data and is simultaneous with data collection according to Morse (1994). The aim of this process is to gather enough data to allow for a clear and comprehensive description of the case study under investigation (Houghton et al., 2015). During the comprehending process, the strategy that should be employed is broad coding whereby raw data (from all sources of information) are broadly categorised under descriptive codes. Although this is the beginning of the analysis, the codes need to be open and broad enough to allow for thought expression and further refinement as the process evolves (Houghton et al., 2015).

In this study, raw data from interviews, focus groups, documents and notes from the observations were entered into NVivo 11. The data were grouped under the status of the participant in order to differentiate the perspectives offered. Therefore, the initial codes were “Professionals”, “Volunteers” and “Mothers”. The document that was included in the analysis

was read and its content was categorised depending on the group of people it was referring to (professionals, volunteers or mothers). The observational notes were categorised under the group(s) that were involved in the session(s) observed.

The second part of the process is synthesising and involves pattern coding and memoing (Houghton et al., 2015). During this process, the aim is to merge the perceptions identified in the initial analysis in order to find patterns in the data. Whereas the analytical process begins by categorising the data (thus fracturing them), synthesising aims to reassemble the data into patterns. In this PhD, this involved revisiting the initial codes and looking for patterns in the data from the interviews as well as the document and observations carried out by the researcher. It was at this stage that themes started appearing and their underlying theories, perceptions and hidden ideologies and agendas became apparent. Another strategy that was employed during this stage was memoing; creating summaries of important information emerging from the data.

The third part of the analysis is theorising. Theorising should not necessarily be interpreted as the development of a theory; it is primarily concerned with the identification of relationships between the patterns found in the data (Houghton et al., 2015). In terms of the strategy that is employed during this process, this involves distilling and ordering the memos in order to understand the relationships between information and patterns emerging from the data (Houghton et al., 2015). This process is active and rigorous, during which constant comparison and challenge of the data is important.

This process allowed me to understand the inconsistencies found in the data that could have been missed had less thorough data collection and analysis methods been used. For example, observational data were contradictory to data gathered from interviews and focus groups. The process of identifying relationships between memos and patterns in the data enabled me to

conceptualise the data and contributed to answering questions particularly around implicit ideologies and philosophies of participants.

The last analytical process is recontextualising (Morse, 1994). This involves making propositions about the data and providing explanations for the phenomenon/issue under investigation. Based on these propositions, inferences can be made as to the applicability of the findings to different settings and/or population (Houghton et al., 2015). Although generalisation is not the goal of qualitative research, the thorough analysis of a case study as well as its comparison with previous theory and research, make some inferences about the applicability of the findings possible.

5.8. Limitations of the case study approach

All research methodologies have certain limitations that need to be acknowledged in order to ensure the trustworthiness of the research. Case study methodology provides an in depth insight into a specific bounded system and it is a well-established methodology in qualitative research (Creswell, 2013). However, many have argued that it is not a methodology due to the presumed lack of scientific rigour in the methods employed. The fact that information sources can be both qualitative and quantitative and the ambiguity around what the data collection should involve has led some scholars to believe that case study methodology absolves the researcher from thinking through the methods employed in the research (Creswell, 2013). Although this may be true for certain case studies, and it is something that has been pointed out in the literature (Houghton et al., 2015) many case study researchers have tried to develop rigorous guides for data and analysis. Moreover, as is the case in this PhD study, robust frameworks for data analysis and reporting have been used.

In addition, the biggest limitation of case study research and indeed of qualitative research is that of generalisability (Berg & Lune, 2014; Bryman, 2016; Walliman, 2005). Despite the in depth analyses and the multiple information sources from which data is collected, assertions about generalisability of the findings cannot be made. Particularly given that a case study takes place in a very specific context which is taken into account when analysing data, it is not possible to assume that the same phenomenon would be experienced, understood and conceptualised similarly in a different context (Creswell, 2013). Nevertheless, the aim of qualitative research is not to generalise; it is rather to understand the perspectives of individuals on a certain phenomenon. In addition, this is in keeping with the researcher's epistemological stance which accepts that generalisability of findings is not the ultimate goal of her research, rather it is to understand the phenomenon in the context of the case study in question. Moreover, by comparing the findings of a case study to the findings of previous studies both quantitative and qualitative can provide the researcher with the ability to make assumptions of how the findings could be transferred to different settings (Creswell, 2013).

5.9. Trustworthiness of the study

Trustworthiness in qualitative research is a concept that has been debated by many scholars both positivists and interpretivists. In positivist studies the concepts of reliability and validity are commonly used to ensure that the studies are trustworthy (Crotty, 2014). However, in qualitative research these concepts cannot be addressed in the same way. In response to this issue, four constructs have been proposed which correspond to the concepts of reliability and validity and are designed for qualitative studies (Shenton, 2004). These are:

- credibility (internal validity);
- transferability (external validity/generalisability);

- dependability (reliability);
- confirmability (objectivity)

Shenton (2004) provides a detailed table of provisions that can be made by a qualitative researcher in order to ensure that a study is credible, transferable, dependable and confirmable all of which contribute to its trustworthiness. Table 5.7 below presents the provisions made by me to ensure that all the quality criteria were met.

Table 5.7: Provisions made by the researcher to ensure trustworthiness of the study

Quality criterion	Provisions made by researcher
Credibility	Qualitative case study methodology is well recognised and appropriate for the study
	The researcher familiarised herself with the participating organisations early in the research process and throughout
	Purposive sampling strategies were employed. However, the researcher ensured that all individuals could provide their accounts by inviting all people involved in the volunteer programme to participate. Special recruitment strategies were used for parents; the researcher made herself available at regular sessions to ensure that as many parents as possible had the opportunity to participate in the study.
	Triangulation via use of different methods was possible through the use of documents and observations carried out by the researcher
	The research was closely supervised by a team and debriefing sessions were frequent
	Presentations of the research were delivered throughout its course both in internal events and conferences, therefore peer scrutiny was sought
	The researcher reflected extensively on her own bias both in terms of the research topic and the research methodology
	The researcher held one undergraduate and two postgraduate qualifications at the time of the research and had experience in qualitative interviewing both from her studies and her employment
	Early findings of the research were presented to participants and their feedback was sought
	A thick description of volunteering and volunteer programme was developed after the initial analysis of the data
	Previous theories and studies on the topic were examined for relevance to this study
	All themes identified by the researcher were presented to the supervisory team and refined using their expertise and objectivity as external to the research individuals.
Transferability	A detailed description of the case study as well as the methodology that was used has been provided throughout the thesis

Dependability	Four types of data were gathered in order to ensure that triangulation is possible
	The methodology and methods that were used in the study have been thoroughly described
Confirmability	Triangulation is possible due to the variety of data collected
	The researcher has reflected extensively on her own beliefs and bias
	The limitations of the study have been acknowledged
	The in depth methodological description of the study allows for the findings to be scrutinised

As this table shows, every effort was made to ensure the trustworthiness of the study. Additionally, the Consolidated Criteria for Reporting Qualitative studies (COREQ) as proposed by Tong, Sainsbury and Craig (2007) were taken into account when designing and reporting this study. The completed COREQ checklist can be found in Appendix M.

5.10. Summary

The study was based on the interpretivist paradigm and adopted a qualitative case study methodology. Qualitative, intrinsic case study methodology was deemed the most appropriate to use as the phenomenon under investigation took place within a bounded system (the FSVP within a specific ward in Stockton on Tees). Data collection involved data from direct and participant observations, documents and interviews/focus groups. Forty-six interviews were carried out during four phases of data collection. Data were analysed based on the framework proposed by Houghton et al. (2015). Adopting the four constructs that were proposed by Guba and compiled by Shenton (2004), I made all attempts to increase the trustworthiness of findings.

6. Chapter Six: Expectations versus reality

The findings chapters, chapters 6 and 7, begin with the presentation of the theory of change of the volunteer programme which I developed (section 6.1). This answers the third research question around the ways in which FSVP was expected to work. Following that, the reality of how the FSVP was implemented will be presented (section 6.2). Both sections serve as introductions to the main findings of the PhD study as they outline how the volunteer programme should have worked in theory and how it worked in practice. The next chapter, chapter 7, will explore in more depth the reasons for the discrepancies between theory and practice.

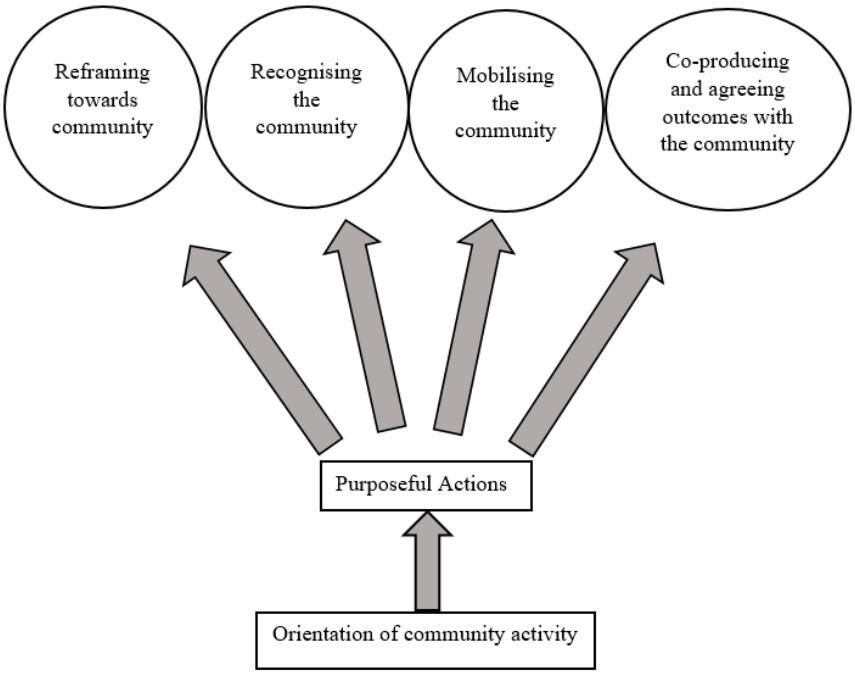
6.1. Expectations (Theory of Change)

As described in the fourth chapter where the programme was introduced, despite the fact that some ideas were present when the programme was designed as to what activities would take place, a detailed, methodical theory of change was never developed by those with strategic responsibility for the programme. However, it can be argued that any programme or intervention which targets specific populations has certain outcomes in mind and aims to produce change, and therefore must involve a theory of change, even if it is not realised, developed or shared with participating individuals (Fletcher, 1984). The importance of uncovering the theory of change lies in the fact that, without it, it is hard to understand what a programme aimed to do, how it aimed to do it and what outcomes it produced or failed to produce (Nilsen, 2015). This is of particular relevance to this study for two reasons; firstly, on a methodological level, and secondly, as it was one of the most significant findings/learning points of the study. To elaborate, methodologically, in order to describe the case study in its totality and in order to ensure that both the case and the research can be replicated, it is essential to be able to outline all the components of it, including the (implied) theory of change.

Secondly, one of the most striking findings of the study was the fact that even though the theory of change was never explicitly discussed, all participants offered important details and underlying assumptions that formed the theory of change of the programme.

Identifying the theory of change retrospectively is not as beneficial as having a theory of change developed as part of an intervention (or before); however, it is still a vital piece of work, since it can advance future intervention development. In order to identify the theory of change of the FSVP, the theory of change as proposed by Rippon and South (2017) and described in section 3.6 of the thesis was adapted and used. This was for two reasons; firstly, because the FSVP did not have a theory of change and secondly because this theory was developed specifically for programmes similar to the FSVP. Therefore, the next sections have been categorised based on the six elements of Rippon and South's (2017) theory of change-adapted to align with the case study under exploration. Figure 6.1 illustrates the theory.

Figure 6.1.: The revised theory of change for asset-based community approaches (Rippon and South, 2017, p.p. 14) adapted for the FSVP.



This theory of change was adapted purely in terms of its wording and not in terms of its content. Rippon and South (2017) place emphasis on the role of assets and asset-based approaches. Although assets are an important part of community-centred approaches, particularly those that use local residents as volunteers, they are not the sole element of focus. Taking the FSVP as an example, the focus of the programme was on community and in shifting the way different groups (strategic stakeholders, health professionals, local government professionals, volunteers etc.) think about community in general. Therefore, the theory of change has been adapted by replacing the word "assets" with the word "community" to be more inclusive of the FSVP's aims. Thus, the adapted theory of change consists of six phases: orientation of community activity; purposeful actions; reframing towards the community; recognising the community; mobilising the community; and co-producing and agreeing outcomes with the community. These are analysed in turn below.

6.1.1. Orientation of community activity

Orientation of activity refers to the initial phase which takes place early, before an approach is fully developed and involves a commitment, a declared action from stakeholders to work towards an agreed approach (Rippon and South, 2017). In other words, during the orientation phase, organisations, agents and communities agree on the approach to be taken and decide its purpose. It is in this phase that implicit and underpinning beliefs, assumptions, ideologies and behaviours should be explored and discussed openly.

In the case of the FSVP, as illustrated in previous chapters, the orientation of activity phase took place to an extent. A common purpose was identified which was to ensure better life chances for 0-3 year olds through culture change, awareness raising, knowledge building and empowering communities to raise children in a healthy and happy environment. Within this vision, the FSVP aimed to increase the number of parents accessing services whilst pregnant,

post-partum and until their child goes to school. It also aimed to help local residents take an active role in their communities, include them in decision making around services and provide support to other residents. Lastly, the FSVP aimed to improve cognitive, social and emotional development, speech and language and nutrition of children, which would give them the best possible start in life. Partners from the VCSE, public and health sectors agreed that a community centred approach would be the most appropriate and cost effective approach to achieve this. It is important to note that contrary to suggestions made by Rippon and South (2017) neither the community nor the local volunteers were involved at this stage.

It is interesting to unpick at this point the assumptions made during this phase. Notably, these assumptions were neither realised nor discussed by strategic leaders in the orientation phase, thus these assumptions were revealed during interviews, observations and documents rather than from the leaders themselves. Therefore, the assumptions reported are findings of this study and not part of the approach.

The first and fundamental assumption made throughout the FSVP was that the best way of ensuring children get a better and fairer start in life is by ensuring that parents access and engage with services to receive support. Despite the fact that local residents would be encouraged to assume an active role in their community with the intention for them to be able to support themselves without support from the state and statutory services, throughout the volunteer programme, increased engagement with services and increased support provision from professionals were required. This forms a contradiction which was neither identified nor accounted for in the initial conversations around the FSVP. In other words, if one of the aims of the programme was to decrease the number of people relying on statutory support, then how would increased engagement with statutory services achieve that?

"How we involve the community and in fact the community themselves empowering themselves to support themselves with us there as specialists to put in that support that needs to go around that." (Strategic Stakeholder J)

It could be argued, however, that if the aim of engagement with services was educational, people would need to engage with a setting where learning is taking place with the view that once educated, people would be equipped with tools which will subsequently give them greater independence. However, if that were the case, a clear programme of educational support would have been developed as part of the FSVP, designed to help people develop and maintain their independence, which was not developed.

In addition, a better and fairer start in life was assumed to be facilitated through the improvement of children's development, speech, language and nutrition. However, interview data showed that none of the participants believed that to be true; they all felt that other, deep-rooted issues are the reasons behind children not getting a better or fairer start in life. The most commonly cited reason was, predictably, poverty, but debt and mental health issues were also mentioned. According to participants, although child development and nutrition outcomes were important and worthy of attention, other issues needed to be addressed first.

"They (Families) are going to talk to you about money, they're going to talk to you about isolation, they're going to talk to you about involvement with social care…what is interesting though is that when you start and talk to them and you unpick all the big words, the majority of them would say they want their children to have a better start than they ever had and the best education they can have.. and it's just about getting them on the right track and using language that they understand and not making them feel as if they're being spoken down to or talked down to and on, on the right level. (Strategic Stakeholder A)

The political climate within which the FSVP operated is important to be mentioned here. Little acknowledgement of structural inequalities and emphasis on individualism are common under right wing governments as presented in the second Chapter. In a local government setting inhabited by people of different political views from the central government, they may find themselves having to achieve targets that are established within the central government ideology, regardless of their personal beliefs and knowledge. Given the fairly limited powers of a local authority, particularly in financial terms, structural inequalities may not be feasible to address and therefore smaller scale initiatives such as the FSVP can provide them with the focus they need to change and address factors within their abilities. Therefore, although participants were aware of the fact that poverty, for example, was the most important factor for poor outcomes for children, this was not something that could be addressed within the remit of the local government. Therefore, focussing on child development outcomes provided them with outcomes that could be addressed.

Moreover, the programme would support volunteers (local residents) to recognise their own worth and the role they play in communities. This, by definition, assumed that local residents are not aware of their worth which, although in some cases may be true, it can also be perceived as patronising and demeaning. However, helping local residents recognise the role they play in communities can be interpreted as an attempt to identify and recognise existing community assets and networks, which is an important step towards community-centred approaches.

> *"You know, Children's Centres have always had some sort of volunteer scheme;, they've always had some of the menial tasks, the admin, the cleaning [of] the toys, that sort of thing. I think this is one of the first times that we've trusted volunteers to actually do true work with families." (Strategic Stakeholder L)*

However, as will be shown later in this chapter, asset recognition and mapping did not occur and, although some conversations around assets happened during the orientation phase, this was not followed through in a systematic way.

Overall, these outcomes as specified in the contract between Big Life Families and Catalyst illustrate that the community of Stockton was perceived as deficient before the programme was developed. It can be argued that, had the community had representation during these initial discussions, these perceptions would have been challenged. Pre-existing assumptions on local residents' knowledge, abilities and needs can be interpreted as patronising and belittling particularly towards local families but also towards potential volunteers. However, the FSVP did attempt to recognise assets and networks existing in the community, although this was neither seen as an important outcome nor realistically thought through. It can be argued that had these assumptions been considered during the design of the programme, as suggested in the theory of change for such approaches, the outcomes would have been less presumptuous and more realistic, closely linked with community-centred approaches and volunteering and less linked to traditional public health intervention approaches.

6.1.2. Purposeful actions

The next stage following orientation of activity is purposeful actions. These are actions that are taken once the intended outcomes have been decided and are specific actions designed to generate opportunities for co-production, vision sharing, outcome identification and evaluation (Rippon and South, 2017).

In the case of the FSVP, few purposeful actions could be identified. As evident in section 5.5.1, some groups were formed with the purpose to identify desired outcomes and how these would be measured; the data, tracking and monitoring group and the operations group. Two points

need to be made here. Firstly, those groups met a few times in the early stages of the project and then ceased to exist. This was because there was little agreement amongst the groups as to what should and could be measured. This was the result of a profound lack of understanding of the FSVP, what it could achieve and how it would be measured. Hence, these groups stopped meeting and the outcomes of the FSVP were never explicitly stated. The second important point to be made is that, similarly to the orientation phase, there was no representation or involvement from the community or the volunteers in these groups. The partners who were part of these groups were trying to identify outcomes that they wanted to measure with no consultation as to what mattered to the community. This is incongruent to the principles of community-centred approaches because the elements of co-production and community involvement were missing.

One of the purposeful actions that should be mentioned is the organisation of a networking event, which aimed to bring together professionals and volunteers working within the programme. However, this event was organised a year after the FSVP's implementation and was attended by only two volunteers. The event consisted of presentations from the leaders of the programme on its principles without, however, giving volunteers a chance to introduce themselves and discuss their involvement in the FSVP. It was organised largely as a formal event which did not allow for interaction amongst people. Although professionals appeared to have an increased understanding of the programme and its intended outcomes, they did not have the opportunity to feed their thoughts back to the programme's leaders and did not have the opportunity to meet the volunteers who attended. Therefore, it was an action with little purpose other than to provide information.

It is important to mention that the information presented in this section reflects on my personal experience from being involved in both aforementioned groups and attending the networking

event. The field notes I kept from those provided the basis for the conclusions drawn here. Generally, therefore, the phase of purposeful actions was not present in the FSVP; neither was the community up to this point in the programme.

6.1.3. Reframing towards the community

The next stage of the theory of change for these approaches is reframing towards the community. This stage involves identifying champions, increasing community-centred dialogue and presenting the knowledge, theory, concepts and evidence around such approaches (Hopkins and Rippon, 2015). This stage is one that should happen early in the development of a community-centred approach.

The FSVP did identify champions, volunteers from the local area who would support the programme by increasing the numbers of registered families with children's centres. It was assumed that families that are registered with children's centres attend sessions and use services which promote or facilitate health improvement, thus resulting in better outcomes for children. In addition, since the majority of volunteer work would be coordinated from children's centres, families' ~~attending~~ attendance to children's centres would result in greater opportunities for volunteers to provide support and advice.

> *"I think we will be able to evidence that families that previously wouldn't have registered with children's centres, we now have engaged with those, very hard to reach families, I think that in itself is a very positive step, that would not have happened without the volunteers." (Strategic Stakeholder A)*

Similarly, having volunteers fully embedded with professionals would mean greater engagement with families both for professionals and for volunteers. This would result in volunteers being able to build rapport with families and address needs or signpost for further

support. Having volunteers embedded and working with professionals would create a holistic package of support for families, as well as empowerment for volunteers, because they would be trusted with more responsibilities.

> *"And they all feel part of the same team. Because one of the crucial things about this sense of teamwork is, the volunteers cannot make a medical referral…but they will certainly know when someone needs some support that goes beyond what can be offered. And for them to say to a midwife or a health visitor or children's centre…so and so really does need some additional support and I will do my best to get them to you but you must be ready to respond to them…(it's important). And for them (volunteers) to feel empowered that if they honestly believe someone needs something that the professionals will immediately respond, I think it's really important." (Strategic Stakeholder D)*

Champions (volunteers) would also facilitate exposure of parents to knowledge around cognitive, social and emotional development, speech, language and nutrition of children. In order for this to happen, and based on the assumption that lack of awareness and knowledge is the reason behind poor outcomes in these early years areas, volunteers would be tasked with raising awareness of their importance. It was hypothesised that if parents knew how important these areas are, then they would be more likely to engage with services in order to support their children and they would take steps in helping their children themselves. Moreover, volunteers, having been trained on early years subjects, would be knowledgeable and confident to talk to families about child development and nutrition needs of their children and could provide advice. They would also be able to signpost to different agencies and refer to professionals when targeted support was required. More importantly, volunteers, having a better understanding of public health and good rapport with families, would be more active in the community and would help professionals shape services according to the community's preferences. This was an assumption, the mechanisms of which were never provided;

explanations or descriptions of how increased understanding of public health leads to increased community involvement in service design were never offered.

It was also anticipated that local businesses would act as champions for the approach. Through enhanced visibility of the programme and the opportunities it can offer to local residents from volunteering to family support, businesses would have a huge role to play in the FSVP. Businesses would facilitate community ownership as well as -perhaps more cynically- result in financial gains through sponsorships. Through this, and combined with volunteer efforts, community empowerment and development were thought to be facilitated. However, this was very much dependent on whether businesses wanted to engage and provide support for volunteers, families and the programme as a whole; no engagement from businesses would mean that this element would be unsuccessful.

> *"The whole delivery was modelled on attending events, branding local businesses, really raising awareness across a wide range of stakeholders, just as a brand recognition and having a sense of involvement in ownership and…when people are in and out of those shops or using businesses or services, they're becoming aware of it…and that's kind of saturating, creating that saturation on a wider model." (Strategic Stakeholder B)*

More generally, the dialogue did shift amongst stakeholders from a deficit point of view towards an asset-based approach. Volunteers were thought of as catalysts for change, who, after receiving robust training would be able to make a difference in their community. The central idea was that supporting volunteers' development would result in increased confidence which would, in turn, result in community empowerment.

> *"Volunteers will need to be able to influence their communities and act as the catalyst to empower change and to make a difference whilst being able to take on new learning and understanding for the Fairer Start Service. A robust training programme will be offered which will include training and briefing on (certain) areas." (Service Specification Document)*

Overall, as part of the FSVP, champions were identified, the dialogue shifted towards community assets and ideas of how knowledge could be transferred and exchanged from volunteers to other community members were in place. However, there are some elements that require a more nuanced exploration. Although it was identified that champions would be local residents, this was done using a top-down approach; that is, their roles and responsibilities were decided by the programme's leaders without any consultation with the local residents. The desired roles for volunteers, namely to get families registered with children's centres, to increase families' knowledge around pregnancy and early years and to act as catalysts for change were all ideas that strategic stakeholders had -not local residents. Similarly, the idea that businesses would act as champions for the approach was based on thoughts from the programme's leaders, not local businesses. This is contrary to the ideas of co-production, bottom-up approaches and indeed community-centred thinking. However, the shift in dialogue towards community assets did happen but it remained theoretical up to this point.

6.1.4. Recognising the community

Recognising the community involves a clear process for reviewing, understanding and mapping community assets as well as the types of assets that exist within the scope (geographical or otherwise) of the approach (Hopkins and Rippon, 2015). This, as mentioned earlier, did not happen systematically for the FSVP. Assets were defined narrowly, in terms of local residents, and were neither documented not mapped. Interview data showed a recognition

amongst strategic stakeholders of the important attributes of volunteers that could be influential in the work with families, but these were general statements, almost idealistic.

> *"Because, you know, there's lots of skills, probably sitting in lots of front rooms, that we are not making the most of. And we (professionals) can go out and visit families and talk to them until we are blue in the face.. But if we can take somebody along who is, can really show empathy, and show that they know what it is like to be in that situation. And actually I was in that situation and look where I am now, the same could apply to you. That would… to me that speaks much more volumes" (Early years professional H)*

The idea that assets are found within people was prominent but the thinking appeared to be narrow. As will also be shown in the next chapter in more depth, no thought was given to other assets such as physical spaces, economic assets, assets within the workforce etc. Moreover, community asset mapping did not occur in any way and therefore little additional information can be provided for this phase of the theory of change.

Some speculations can be pertinent as to why this stage was missed. The FSVP was commissioned out by Catalyst to BLF and the contract was specifically around recruiting, training and managing volunteers. Community asset mapping was not part of the contract as it had already been decided that volunteers would be the assets utilised. Based on my observations, this notion around assets was not challenged; that is, no one suggested that assets extended beyond people and that other forms of assets should also be explored or mapped. Therefore, assets were recognised as far as volunteers were concerned but did not extend beyond that.

6.1.5. Mobilising the community

Mobilising the community refers to the actions and activities designed to utilise community assets for specific purposes (Hopkins and Rippon, 2015). The main idea, which informed the

activities designed, was to have volunteers work alongside professionals. In theory, volunteers would help professionals by supporting them with tasks that they have no time to complete. For example, midwives have to follow up pregnant women who do not attend (DNA) appointments, which was thought to be a task that volunteers could take over to save time for midwives. Another thought was that volunteers could be interpreters for appointments with pregnant women from different countries. However, this presumed that professionals wanted that involvement.

> *"We have a DNA follow up, which is did not attend, and .. we still need to try and find out where she is, so, even if she doesn't come to a hospital clinic or community one, we will follow up. So having a Community Champion (will) hopefully take some of the burden off the midwives. (Strategic Stakeholder G)*

In addition, it was also assumed that the work alongside professionals would lead to volunteer involvement in service design and provision. This was an ambitious assumption to make considering the mechanisms by which that would happen were unclear. It can be argued that this assumption was based on the idea that working together would lead to conversations between professionals and volunteers about the services provided, the volunteers would offer their opinions on those services and professionals would take them into account. However, no mechanisms were put in place for this to happen. It would be dependent on whether these conversations took place and, even if they did, it was dependent on the professionals to act on them. Overall, it was assumed that professionals would be happy to work with volunteers to support families, which, as will be shown in the next chapter, was not always the case.

An important aspect of the activities that were designed for the programme involved local businesses. The theory behind this saw businesses offering work placements for volunteers, displaying information around family sessions within children centres and signposting families

as appropriate. Businesses would also offer goods or services towards the rewards catalogue, a catalogue of incentives that volunteers would be entitled to, following completion of an agreed amount of volunteer hours worked. In recognition of their contribution, businesses would feature in promotional materials as well as get help from volunteers towards business needs. This theory was heavily based on the assumption that businesses would get on board with the programme, subscribe to its values and promote it accordingly. Low business engagement would mean failure of a big part of it, which would leave volunteers without incentives, and the programme without half of the promotional efforts it expected.

With regards to volunteers, it was anticipated that, through personal development plans and appropriate training, their self-worth, confidence and self-esteem would increase, which would lead in them assuming a more active role in the community which again, would aid the community development and empowerment aspect of the programme. This presumes that the personal development plans and the training programme are fit for this purpose, the personal development plans are reviewed and adapted regularly and the training programme provides volunteers with the knowledge they need to feel confident in their role. Similarly to previous assumptions, the mechanisms by which community empowerment and development would happen were not clear. It can be argued that although the terms were used widely both in documents and by participants, they were not understood as well as perhaps they should when designing a programme that partly aims to aid community development.

With regards to other activities, community events would be organised by volunteers taking place in Stockton Town Centre and aiming to engage with families. This, however, presumes that families want to engage in that way, are interested in getting involved in activities on the street and have the time to spend speaking to volunteers. This aimed to engage the “hard to reach” families that refuse or fail to attend and register with the children’s centres.

6.1.6. Co-producing and agreeing outcomes with the community

The last phase of the theory of change is around co-producing and agreeing outcomes with the community. This stage is similar to the mobilisation of the community but includes (or should include) co-production with the community. It also involves the development of the context and rationale for community-centred change by strategic stakeholders (Hopkins and Rippon, 2015). With regards to the co-production element, this was not evident in any of the data sources used in this study. Opportunities for the community to actively participate in the development and implementation of the FSVP were not provided. Additionally, co-production with community assets was not facilitated. Despite the evidence above that volunteers were identified and recognised as assets, they were not involved in the decision making for any aspect of the FSVP. Their roles and responsibilities had been decided before they were recruited and there was little opportunity for feedback and adaptation based on their thoughts, ideas and needs. In this respect, the programme adopted a top-down approach rather than the opposite as claimed.

However, the system leaders did try to enable the context and climate for the approach to work. The funding provided for the infrastructure of the FSVP was significant. The programme's budget was £72,381 per year and £217,143 over its 3-year course. This funding supported three part time staff members, training costs for volunteers, community events and activities as well as overheads. The rationale that justified the allocation of this funding to the volunteer programme was that it is much lower compared to the cost of children entering social care due to reasons that the volunteer programme sought to tackle early.

" I mean it costs, the contract is around £75,000, and then obviously there's other costs but that's how much it costs for them to run a year, the whole of that programme…And it doesn't cost a lot, if every year they just meet one woman who's going to have a baby who could get all the proper care and support that they wouldn't have otherwise accessed, it's worth it. And each child who goes into local authority care costs a minimum of £150,000, and that's minimum." (Strategic Stakeholder D)

In addition, system leaders supported the fundamental idea that volunteering is an effective (both in terms of costs and in terms of outcomes) approach to improve public health in early years and that it can facilitate community empowerment and development. However, there was no research activity to identify the effectiveness of such approaches before the decision to fund a volunteer programme was made. Therefore, this idea was either the result of financial pressures or a combined set of assumptions described throughout this section. Participants' accounts showed that both occurred; for some the programme was the inexpensive alternative to paying health visitors or midwives and others believed in the effectiveness of the approach based on a set of assumptions.

"So you can utilise the skills that you've got from the community, particularly the Fairer Start volunteers, without that additional cost. Because we don't have any money at the minute" (Early years professional I)

"I see it as an investment rather than seeing it as necessarily cost saving, or a cost full stop. I think it's a true investment and it...it will be how we work going forward. It will just be part of the system. The challenge is keeping people engaged so that they want to continue to volunteer." (Strategic Stakeholder M)

Another rationale provided for the programme was that volunteers could help and support professionals in their work and therefore professionals would (and should) welcome it. It was assumed that professionals would support the programme and its volunteers for two reasons;

firstly because the holistic support provided by volunteers and professionals would be perceived as necessary from professionals and secondly because, given the pressures they are under, professionals would welcome the extra help with their workloads.

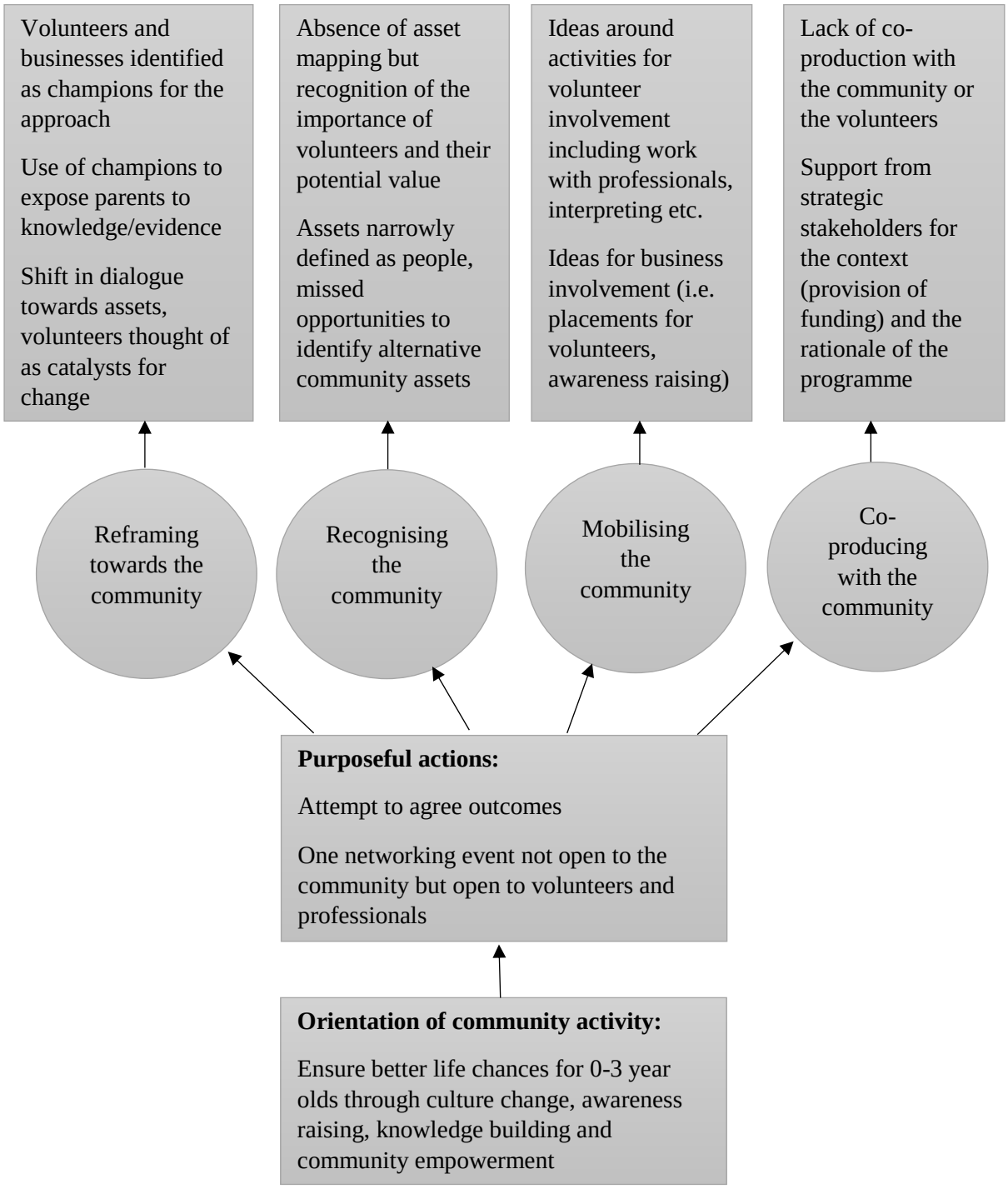
> *"We're slightly different in our community areas for midwifery and health visiting, all our clinics are ran from the Children's Centres so we've been engaged in the community area for a long time, we embraced the pram pushing ethos quite a few years ago, really more than 10 years ago. So actually we've always been there and we've always been in the Children's Centres…but now with the volunteers and everything else it's the more holistic approach." (Strategic Stakeholder G)*

To summarise this section, a theory of change was not developed as part of the FSVP. However, a covert theory of change did exist in the assumptions, ideas and beliefs of the stakeholders involved in the programme. As part of the identification of the implied theory of change of the FSVP, I adapted a theory of change as proposed by Rippon and South (2017), using data from documents and observations as well as interviews and focus groups. In terms of the proposed stages of the theory of change, the FSVP had an orientation or a rationale for introducing the programme and had an overarching purpose that it aimed to achieve. It lacked purposeful actions in that opportunities to share the programme's vision with stakeholders and the community were few.

The programme went some way in reframing towards the community by identifying champions in volunteers and local businesses and forming a plan of how to expose parents to knowledge and evidence. Community asset mapping was a stage that did not occur. Actions and activities designed to mobilise the community were developed but they lacked co-production with the community. Lastly, strategic stakeholders enabled the climate, context and rationale for the approach by providing funding and therefore the infrastructure of the programme as well as a

rationale to adopt the approach. In order to facilitate a clear understanding of the theory of change of the FSVP, Figure 6.2 was developed following data analysis.

Figure 6.2.: The theory of change for the FSVP (adapted from Hopkins and Rippon, 2015 and Rippon and South, 2017)



6.2. Reality of the programme

Chapter 4 presented the FSVP in its inception and the way in which it was designed. The previous section presented its theory of change; the assumptions that were made in the programme's design, what it was meant to achieve and how it was thought it would achieve it. Perhaps not surprisingly, the expectations of how the FSVP was supposed to influence change were largely different to the reality. Therefore, the findings chapters would be incomplete without the presentation of the programme's reality; the way in which the programme actually worked, the changes in its aims and objectives and the changes in its design. This serves the purpose of clarifying which elements of the volunteer programme worked as originally thought and which elements were abandoned. The structure of this section will follow the structure of the second chapter to maintain consistency.

Because the reality of the FSVP was shaped by external factors as well as internal to the programme, this section will begin by outlining relevant developments that put the findings of this study in a wider context and explain, to an extent, the shifts in decision making throughout the FSVP's course. In 2012, under Health Secretary Andrew Lansley, the new Health and Social Care Act was published in which several NHS reforms were announced. The most relevant of those reforms was notably the transfer of public health out of the NHS and into local authority control. Following those reforms, which came into force on the 1st of April, 2013, health visiting was also transferred into local authorities from the 1st of October, 2015. Both local authority and NHS employees were still making big adjustments to this shift, which was going on as part of the backdrop to this initiative, thereby exacerbating a lot of the professional tensions and uncertainties. In addition, the scale of the austerity measures applied after 2009 was becoming clear. Central government was reducing grants to local government year on year, requesting more and more efficiencies. These issues inevitably resulted in

frustrated professionals on both sides, who, although understood the need for efficiencies, simultaneously felt overstretched and devalued.

In addition to these issues, children's centres in Stockton-on-Tees were reviewed and restructured twice during the FSVP's life course, which meant that early years professionals faced long periods of uncertainty and job insecurity. Lastly, towards the end of the FSVP, it became known that the NHS Foundation Trust that was contracted to deliver the 0-19 health programme in Stockton-on-Tees decided not to bid in order to re-deliver it, resulting in numerous staff leaving or transferring to a new employer. Whilst these issues did not necessarily affect participants of this study directly, the fact that these major policy and service changes took place almost continuously, particularly from 2015 onwards meant that job insecurity, fear and anger were predominant feelings for many and were evident in some interviews.

Moreover, and with regards to volunteers, six out of nine volunteers who took part in the study were seeking asylum in the UK at the time of the interviews. This is important as it has implications for volunteers' rights in the UK. Under UK law, asylum seekers cannot work whilst their claim for asylum is being considered by the Home Office (Home Office, 2017). In addition, the Home Office encourages asylum seekers to volunteer: "Volunteering involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to, close relatives. By volunteering for a charity or public sector organisation, asylum seekers can support their local community, and this will also assist with their integration if they are granted leave to remain in the UK." (Home Office, 2017, pp. 4). This is important as it provides the backdrop against which volunteers were recruited into the programme.

Given this wider context, the programme was initially designed as a public health intervention with a smaller element of community development; however, this changed during the initial implementation stages since A Fairer Start, the wider intervention of which the programme was part, also changed its focus. Interview data showed that this was done as a result of stakeholders' realisation that AFS was not, and should not be, merely a public health intervention delivered for a period of time and then taken away; it should rather be an initiative that facilitates both systems change within early years workers and community development. The community development element therefore, fell onto the volunteer programme to address.

> *"We had senior buy in the ethos but that should be from the community up and not top-down. And everyone around the table at that point recognised that it needed to be...a bottom-up but...some of the cost savings, and some of the money could come from service redesign, and working in different ways so it didn't necessarily mean that it needed to have cash but if we could work slightly differently we could potentially save some money and streamline things and make things more efficient." (Strategic Stakeholder E)*

With regards to the overarching outcomes for both AFS and the volunteer programme, these were never formally changed but the idea that AFS was an "ethos" rather than an intervention was shared amongst stakeholders. Thus, instead of working towards improving cognitive, social and emotional development, speech, language and nutrition, the outcomes changed to supporting the community as a whole with any issues they may have. This in itself may reflect the gradual culture change in public health which was shifting from an NHS, largely top-down approach prioritising brief, measurable interventions to a local authority approach focussing on less easily measurable and more diffuse community outcomes. As the quote below illustrates, the idea moved from specific health outcomes to a whole systems approach to health and wellbeing.

"My approach was actually, yes we need to focus in on the three outcomes but creating a community asset base which isn't focussing on those three things but is actually looking at just life in general, life skills, quality of life (is needed)….because there are layers and layers of multiple and complex issues that are linked to mental health, drug and alcohol, domestic violence and the community…so if domestic violence is happening, your neighbour isn't going to say anything because it is accepted… and what you're trying to do is, by addressing all those (issues), then you're going to be more readily able to engage with mums around all areas of development." (Strategic Stakeholder A)

Participants' accounts mentioned a broad range of issues that support could and was provided for; from domestic violence and debt to mental health and advice for asylum seekers. It is therefore apparent that the volunteer programme, due to mainly external circumstances, morphed into a community development initiative rather than a public health intervention as such.

6.2.1. The vision and approach

Interestingly, despite the fact that the outcomes changed considerably, the vision of the volunteer programme remained the same. In other words, the volunteer programme was still trying to improve access to local health services, provide health related information and signpost to appropriate services, whilst simultaneously trying to empower individuals (both service users and volunteers) in order to facilitate community development.

The approach that was used however did change over time. The aforementioned strategic changes as well as the fact that senior leadership within the volunteer programme changed meant that the initial model of two types of volunteers (Family Champions and Community Heroes) was discarded and a new model of only one type of volunteers was adopted. Instead of differentiating between volunteer work, it was felt that all volunteers should do different

types of work. In other words, whereas in the first model a volunteer would have to choose one role, the second model allowed the volunteers to try different types of work should they so wish.

> *"We used to have lots and lots of different roles for them (volunteer)…what we're saying now is, they all come under this Buddy Community Champion, and they have a ten week programme to follow with our Outreach Team. But, then there's lots and lots of other things inside those roles as well, like training them on dental health, home safety, they're all doing smoking cessation, to incorporate in that role so whether that buddy is out and about in the community delivering a session and promoting health and wellbeing or they're linked up with a particular family, from a referral that comes in, they utilise their skills and experience. (Early years professional C)*

Therefore, both the vision and the approach were broadened to allow for adaptation into the new outcomes as defined by AFS.

6.2.2. Community engagement, empowerment and development

In many respects the terms community engagement, empowerment and development were used interchangeably by numerous stakeholders, which will be further explored in the following sections of the findings. From the initial description of the programme, it was apparent that the terms were used more as "buzzwords" and less as meaningful targets that the programme was aiming to achieve. However, the ideas put forth around community engagement and the involvement of local businesses to facilitate it were interesting.

Nevertheless, and for reasons that remain unknown, despite my best efforts, the business involvement element never materialised. One can speculate as to why that may have been the case. Businesses have been previously used as part of public health awareness raising efforts, for example, shops have signed up to promote five a day for fruit and vegetables or to promote

and support breastfeeding. Ultimately, however, there is little gain for businesses that decide to promote such efforts and although, as part of their corporate responsibility they have funds to support local communities and projects within them, it is not necessarily aligned with their overall corporate strategy. Some accounts mentioned that a big supermarket chain was on board with the idea initially but, overall, this element of the programme was abandoned. A participant explained that one of the reasons for businesses to sign up to support the programme was that their business would feature on the official AFS banners and promotional materials. It was felt that delays in designing, finalising and producing the branding for AFS may have contributed to the low engagement of businesses. In addition, staff turnover may have also played a role in the low participation of businesses in the programme.

> *"the other thing was this concept of shifting the curve, where you look at your stakeholders and you saturate something so the aim for me was yes, we need volunteers with life experience and then…we need something about branding and giving a level of recognition…so in this instance businesses and wider organisations (were needed) so everybody would be able to recognise (AFS) and offer a level of contribution, for example, businesses, local shops, we would badge them up, maybe something on the window that says we're A Fairer Start, from that through to creating maybe a small play area once every week in the shop through to the shops like [big supermarket chain] promoting awareness of that, promoting healthy eating, that type of stuff. (Strategic Stakeholder A)*

> *"But other elements were a bit slower so we took hold of that, we did the branding and the logo work because we needed that to go out there and launch the programme, so there was a few delays relating to that but what we did was we said we'll do it." (Strategic Stakeholder A)*

The lack of business involvement meant that the promotion of the programme was not as successful as originally thought within the community. In addition, services and goods were not provided for the volunteer catalogue (to be used by volunteers once an agreed amount of

work hours was completed) and support for pop-up community events from businesses was non-existent. Moreover, volunteers did not get the chance to work within businesses as part of an "exchange" agreement as initially planned. The interesting ideas around "Fairer Start Friday" whereby supermarkets would provide healthy eating giveaways and health and wellbeing prize draws never occurred and the promotion of loyalty cards so that families were encouraged to buy healthy food items did not happen. Some interview data from senior stakeholders outside of the volunteer programme indicated a lack of faith towards the presumed success of the idea altogether. This could explain the reasons behind the abandonment of this element; without buy in from senior stakeholders there is a lack of drive and lack of drive for ambitious projects like these means that they can be abandoned. Generally however, despite persistent efforts to gather data around this element of the programme, none of the participants were forthcoming.

> *"And I think they (businesses) sponsored some of the events. Like I think [big supermarket chain] sponsored some of their sessions, they gave free fruit and things like that. There was also something around them (volunteers) being able to, when they were using their volunteer hours, this was the principle, that…with the rewards catalogue they might offer them like ten percent off or something like that. But I just don't think it ever happened. They had this whole I suppose vision that they'd make the town centre into like a Fairer Start town didn't they? But I don't think that worked" (Strategic Stakeholder F)*

One of the realities around this is that, as illustrated from the quote, participants were unaware why this element failed. Indeed, this idea came from strategic stakeholders in public health and community development and therefore it can be argued that they were simply unaware of how the corporate world operates. Given that there was no representation from the business community in any of the groups formed as part of the programme, a simple explanation would be that businesses were not consulted and therefore the vision was not right for them. More

importantly, there was a lack of leadership around this element of the programme which meant that no one was responsible for its development and therefore was abandoned.

With regards to the community pop-up events which formed the second part of the community engagement element of the programme, these followed a similar route to the business involvement element. Although participants mentioned some initial pop up events taking place in central locations within Stockton Town Centre, these were quickly considered unsuccessful and stopped. Lack of interest from the community, families and children was cited as the reason behind this decision. It was acknowledged that, due to the fact that the target populations were "hard to reach", they had little interest in taking part in outdoor events which aimed to promote health related activities.

> *"We still struggle with community, we're working with the hardest to reach population group and trying with engagement, it's very, very difficult… (The volunteers) they've always got the support and encouragement, we sort of say, yes, it is disheartening but, let's work together and find out the reasons why and also what we can do to change that, rather than just say, oh it's not working, let's just give it up…How can we tackle it? How can we challenge it? What can do to try? What services can we get involved there? What does that community actually want? Maybe we're trying to deliver something they are just not interested in, okay, well what are you interested in? And that creativity, I think they need that. Be creative." (Early years professional C)*

The programme therefore moved towards a children's centre based approach (compared to outreach work) whereby regular stay and play sessions, read and talk sessions and eat and meet sessions were scheduled and families that were interested attended. Community engagement (or lack thereof), remained an issue throughout the duration of the volunteer programme and despite efforts to adapt and change, it never improved. Therefore, the community engagement, empowerment and development elements of the volunteer programme worked vastly

differently than planned, as the business element never materialised and the pop-up outdoors events had to change format.

6.2.3. Targeted intervention

As far as the targeted intervention was concerned, the initial idea was that volunteers would train alongside health visitors, midwives and children's centres employees in order to develop their understanding of early years and public health and support professionals' work. The target was that they would engage with approximately 300 families and provide outreach support, family support and awareness around child development, speech, language and nutrition. However, this element also proved problematic, largely due to professionals' resistance towards working with volunteers (this will be explored further in Chapter 7, section 7.2).

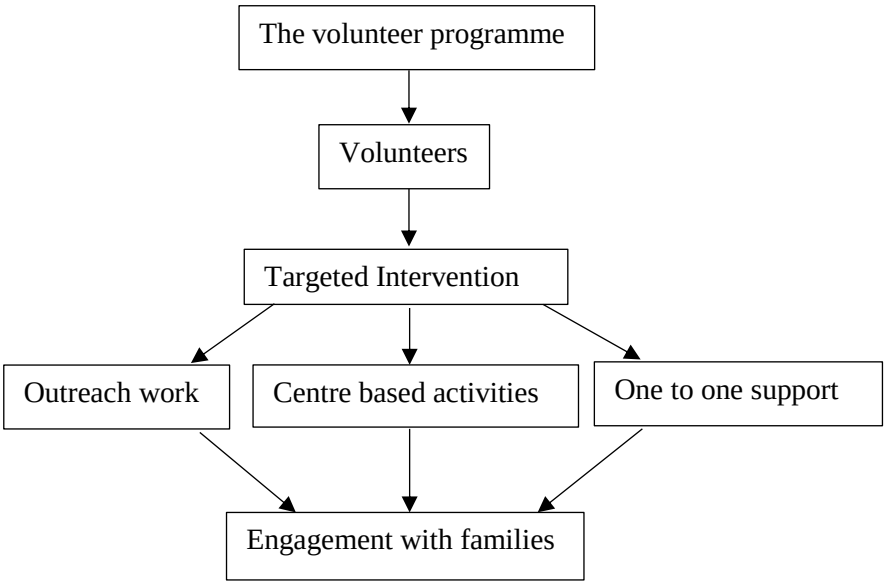
Another interesting point to draw out about the targeted intervention element is that, although volunteers did receive training from Big Life Families around public health and child development, this was never alongside professionals as originally envisaged. Perhaps if volunteers and professionals had trained together, some of the resistance would have been dissipated. Equally, professionals never received training on how to work with volunteers, what types of volunteer support they could have etc. This, again, could have made a difference in the way the programme worked in reality.

> *"I was disappointed in that really, because we always said right from the beginning, that when we were looking at culture change, and embedding change, that those volunteers would train alongside those professionals, and I think that would have built a big relationship. It has built relationships between all of our different branch of organisations…but what was massively lacking is those relationships haven't been built up with health professionals, with the practitioners from Children's Centres, with nurseries in the area, with lots of different organisations, and they should have been. (Early years professional C)*

Nevertheless, volunteers did conduct outreach visits with children's centres staff and provided befriending support to families, particularly mothers who were new to the country and thus isolated. Although targeted intervention had to adapt to the realities of implementing a volunteer programme (i.e. professionals' resistance to working with volunteers), it was an element of the programme that was delivered.

Similarly to section 4.5.3 which visually presented the FSVP as it was supposed to work, Figure 6.3 was developed to reflect its changes.

Figure 6.3.: The reality of the programme



6.2.4. Volunteers

Similarly to all other aspects of the programme, the volunteer element also had to evolve and change to respond to the needs of both external agencies (i.e. commissioners) and the community. There was only one type of volunteers recruited, the characteristics of whom will be analysed further in the next chapter. With regards to the training volunteers received, it

centred around safeguarding and health and safety. The AFS specific training programme was provided on a non-mandatory basis whereby volunteers chose which courses interested them. In reality, a number of volunteers utilised these courses as a way to learn about how to raise their children and how to ensure their children were healthy.

> *"I'm doing more courses, I just signed up to do more courses in September, mental health, autism and health and social care level 1 so I'm building up my (CV)". (Volunteer C)*

On the other hand, and in terms of the support available to volunteers, it was not as thorough and comprehensive as originally thought. The I-statements that were used as personal development plans were completed but not monitored as frequently as envisaged. In addition, the supervisory meetings with other volunteers and volunteer coordinators did not happen. This was partly due to capacity issues, as the two volunteer coordinators that were employed worked part time hours. In addition, the operational lead for the programme was on long term sick absence. However, additional support in the form of enrolling volunteers to college courses, English and Maths courses and other educational courses as required was provided, which volunteers were grateful for. In some cases, volunteers received CV writing support and advice regarding university courses. With regards to incentives however, due to the lack of business involvement, the volunteer catalogue could not be developed and therefore volunteers did not receive any incentives as initially planned. For some volunteers this was an issue, but the majority of them did not discuss the lack of incentives as a problem.

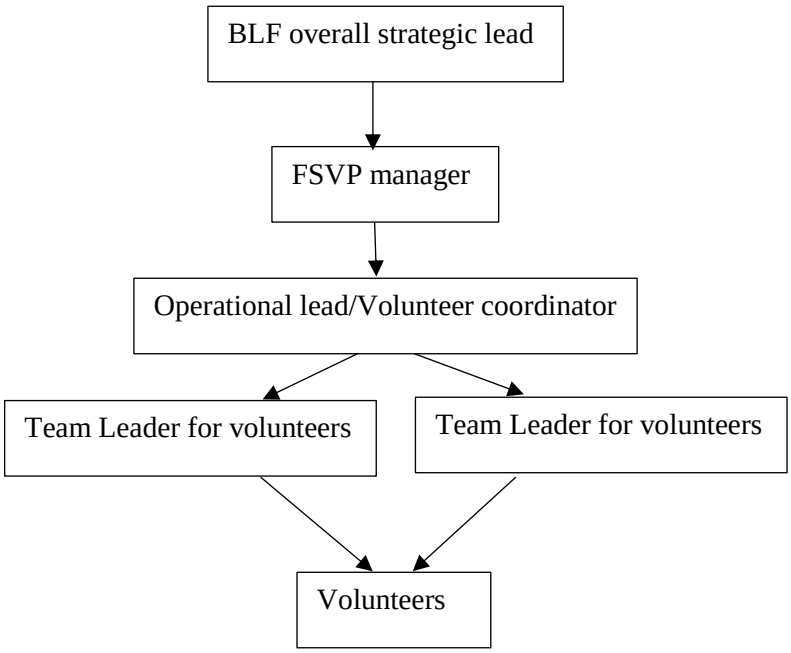
> *"If the rewards could be there...that would work very good for the average person, to hook them onto volunteering, as a motivational thing.." (Volunteer B)*

Generally, despite the changes in both the roles and the training of volunteers, they all appeared pleased with the experience. The support provided was fit for purpose and the lack of incentives did not affect volunteer recruitment or retention (within the timeframe of the study). However,

accountability issues were obvious, particularly due to lack of supervision and appraisal from staff.

With regards to the management structure, although it was not altered to accommodate the changes in the programme, several issues were present that need to be reported. Figure 6.4. presents the structure.

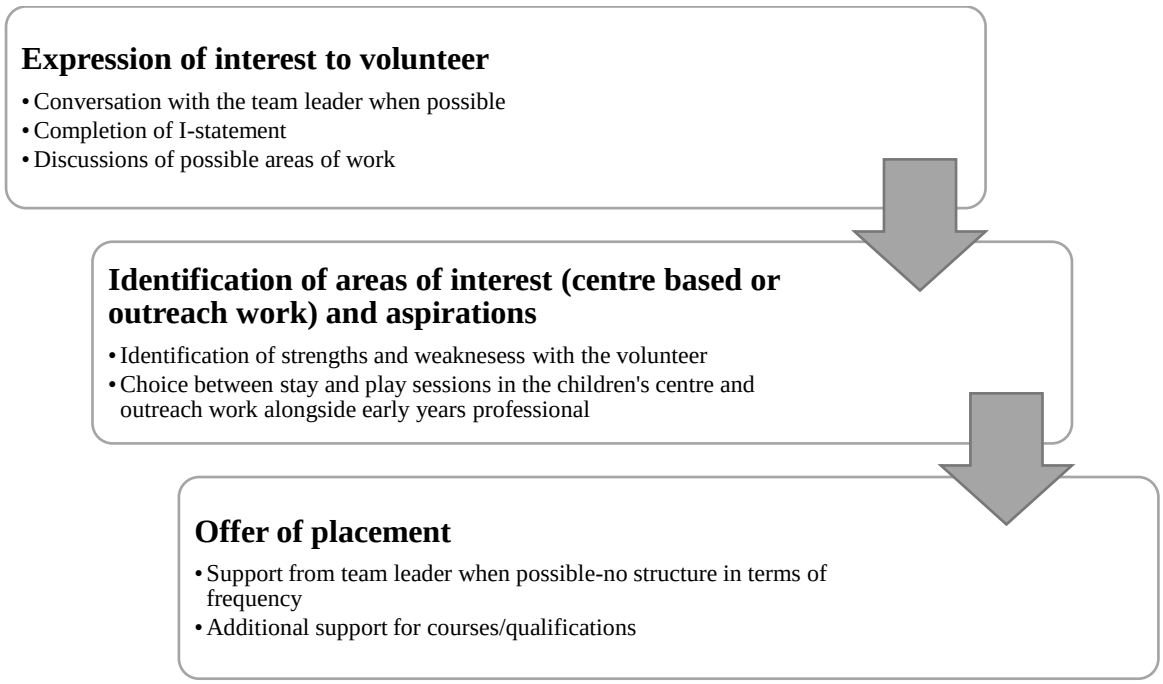
Figure 6.4.: The management structure of the FSVP



The circumstances, which affected the management of the programme, fell into two categories: resource and capacity issues and unforeseeable changes. The original FSVP manager retired a year into the implementation of the programme. A new manager was appointed with reduced capacity; this meant that the FSVP was part of the new manager's responsibilities but made up only a small proportion of their workload. In addition, the operational lead/volunteer coordinator and the team leaders were employed on a part-time basis throughout the programme; the operational lead for 0.6 FTE, and the team leaders for 0.4 FTE each. This meant that capacity was a problem throughout the programme thereby exacerbating doubts and

uncertainties around volunteer management amongst the workforce. Moreover, the operational lead and one of the team leaders were on long-term sickness absence for six months and nine months respectively. This meant that the new manager employed had the strategic overview of the programme but lacked the operational knowledge that the volunteer coordinator and team leader had. This resulted in changes in the volunteer roles, structures and journey. Therefore, Figure 6.5. was developed to illustrate the volunteer journey in reality.

Figure 6.5.: The volunteer journey in reality



This figure illustrates the volunteer journey as linear and as clearly as possible. However, as one of the biopics found in Appendix L shows, the volunteer journey was not as prescribed as this figure implies. Volunteers' accounts suggested that their roles, responsibilities and titles changed over the course of their journey, as did their management. The only aspect that remained constant throughout was the support for their own aspirations and personal goals.

6.2.5. Outcomes

With regards to the numerical outcomes that the programme set out to achieve, out of its main targets to engage with 300 children annually, to recruit and train 40 volunteers in the first year and to sign up a minimum of 30 businesses over 3 years, none of them were actually met. For reasons that will be explored in the following findings sections, these targets were not realistic for the duration of the volunteer programme.

The original outcomes around improving school readiness, increase uptake and engagement with services, improve child development and nutrition, could not be measured by the programme's evaluative activities, the official evaluation of AFS or the commissioners of the volunteer programme. Due to the lack of structure of the volunteer programme in terms of the activities and support provided to families, any objective measurement of such outcomes would be futile and unfair. On a similar note, community development outcomes around local residents' involvement in shaping services, engaging the "hard to reach" populations and increasing understanding of early years and health in the community, were also impossible to measure in an objective way. This is not to imply that no outcomes were achieved or that the volunteer programme was a waste of time and money; some interview data reveal that mothers felt well supported and the programme helped them and their children integrate into the Stockton community.

> *"Yeah because the drop in session, the stay and play it's very helpful for the kids, their communication. They are bilingual so it's really helpful to them and they make friends here and I have made friends here too." (Mother C)*

> *"When I came from my country just I knew 'hello', 'how are you', 'good morning' when I started here I could speak slowly slowly. To be honest I improved my language here but then I needed more." (Mother D)*

6.2.6. Evaluation and review

Although the evaluation and review measures were thought out in the inception of the programme, the reality of its implementation and the issues mentioned above can only mean that they were less effective in practice. Interestingly, anecdotal evidence from stakeholders outside the volunteer programme revealed that the commissioners were made aware of some of the operational issues faced but at the time were occupied with the systems change aspect of AFS and therefore decided not to act. Lack of trust in the way the programme was ran and confidence in the systems change aspect of work were cited as reasons for the lack of monitoring, evaluation and review of the programme.

This concludes the outline of the volunteer programme as it was implemented, and serves to illustrate the differences between what was designed and what was delivered. It is vital that this evolution is documented alongside the reasons behind it so that the future of community interventions can advance. With regards to the specific research questions of this PhD, this section provides an insight into the elements that influenced the FSVP and inevitably shaped the way impact was achieved.

6.3. Descriptive framework revisited

Similarly to the use of the descriptive framework by South et al. (2013) in the fourth Chapter which outlined the FSVP as it was designed, the same framework has been revisited and updated to reflect the FSVP as it was delivered:

Table 6.1: South et al. (2013) descriptive framework reapplied to the volunteer programme

Intervention dimension		Role dimension		Service dimension		Community dimension	
Health issue(s)	Primary outcomes: Support the community with any need health or social. Overarching outcomes: Child development, speech, language and nutrition- overarching aim to improve school readiness	**Primary role/function**	All volunteers have the same roles and functions: raise awareness in the community, provide buddying support and refer to services as required.	**Training & development**	The training for both types of volunteers focused on both preparing them to deliver elements of the programme and developing them personally as individuals	**Lay (community) designation**	All volunteers were expected to be local to Stockton Town Centre; all types of volunteers were required, non-professionals, peers to recipients and embedded in the community
Horizontal or vertical programme	Vertical programme in that it addresses numerous issues through health promotion	**Core and subsidiary responsibilities/ tasks**	Buddy Community Champions focus on outreach work working alongside a member of children's centre staff as well as receiving appropriate and relevant training	**Payment**	None	**Accountability**	Professionals identify volunteers. Volunteers giving access to community for professionals as well as working with it
Community of interest (target population)	Work with predominantly families with young children (regardless of age) although emphasis on pregnant women, children 0-3 years old and their families but also the community as a whole	**Expertise sought**	Experiential, embodied, cultural and linguistic	**Extent of autonomy**	Volunteers worked with children centre's staff but not other professionals as expected	**Social networks**	Volunteers using both their existing social networks but also develop new ones to reach the "hard to reach"
Intervention method(s)	Relatively unclear-support with any needs as necessary through signposting and referring.	**Mode of working**	All volunteers worked with individuals, groups and the wider community				
Setting	Community based particularly around children's centres						
Delivery organisation (sector)	Voluntary, Community and Social Enterprise Sector (Big Life Families)						

6.4. Summary

The aim of this chapter was twofold; firstly to present the theory of change of the volunteer programme as discovered during the analysis of the data collected. This theory was never made explicit from the people who designed the programme; it is the result of my analysis based on the commissioning contract and the interviews with participants. The section was structured based on Rippon and South's (2017) theory of change for asset-based approaches, adapted to fit the FSVP. The analysis also included the assumptions made by the programme's creators as apparent from the activities they put in place to achieve the outcomes.

Several assumptions guided the development of the programme but a few were more influential on its course than others. It was assumed that volunteering is an effective approach to use when trying to improve public health and early years outcomes as well as promoting community development. In addition, it was assumed that parents are unaware of the importance of child development and nutrition in early years and they need a combination of professional and volunteer support to improve their understanding and subsequently outcomes for children. Lastly, it was presumed that recruiting volunteers and providing them with training in public health in early years would lead to increased confidence and self-worth which would consequently lead to individual as well as collective community empowerment.

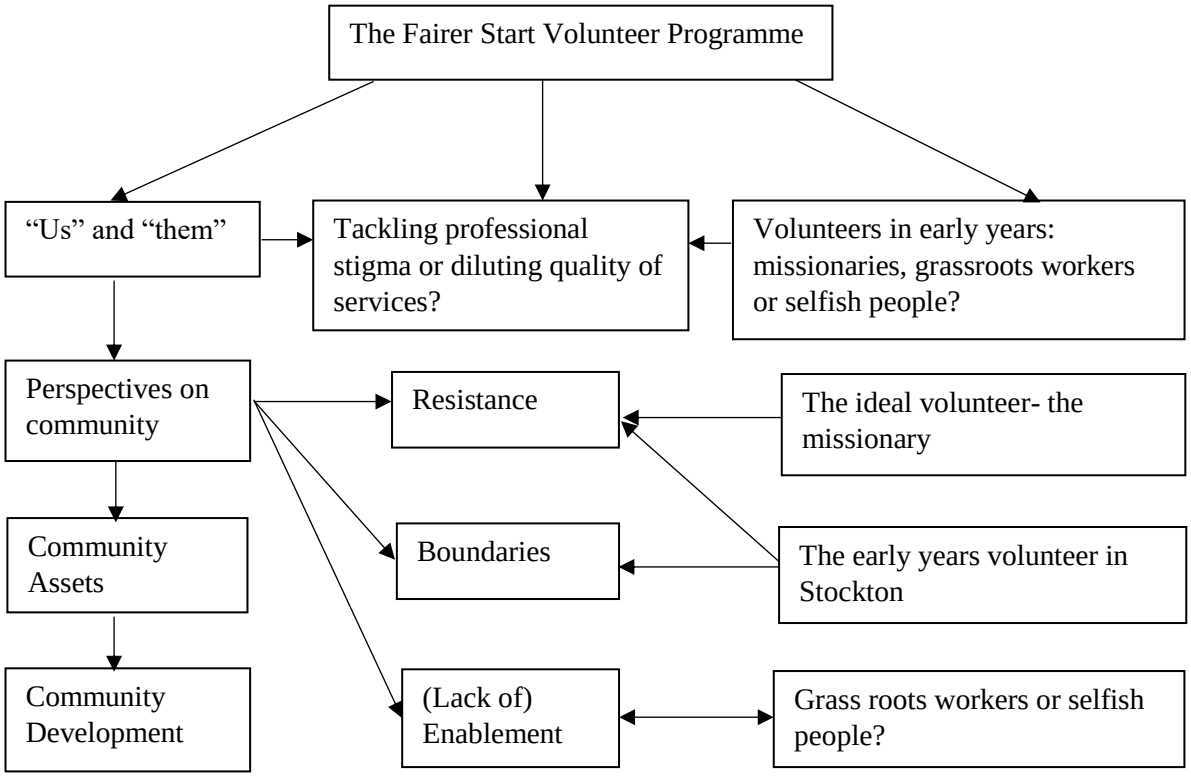
The second aim of the chapter was to provide a realistic context of what the FSVP was and what it achieved. It was important to present the idea of the programme first (in the fourth chapter) and the reality of the programme in the findings so that the reader can understand both the origins of the programme as well as its evolution. This is important for two reasons: firstly it helps the reader understand the context in which I set out to study the volunteer programme as a case study; secondly it helps other researchers and interventions designers realise some of the pitfalls and problems with intervention design, implementation and delivery.

In the next findings chapter, chapter 7, some of the assumptions in the theory of change are explored and analysed further and some of the reasons behind the practical issues of the programme will become apparent through the presentation and analysis of the three major themes that were developed.

7. Chapter Seven: Community, professionalism and volunteering

This chapter explores the major themes that emerged from the research and relate to all research questions. The chapter is divided into three sections corresponding to the three major themes of the study: “us and them”, “tackling professional stigma or diluting quality of services?” and “volunteers in early years: missionaries, grassroots workers or egoists?”. Following a thorough description of the major themes and subthemes a summary is provided in which the main points of the chapter are emphasised that lead to the final chapter; the discussion. Figure 7.1. below shows the themes and subthemes as they were identified.

Figure 7.1. Illustration of the themes



7.1. "Us" and "them"

The volunteer programme as described in previous chapters was a programme using a community-centred approach. Thus, the terms *community, community assets and community development* were discussed at length by participants. The term community was naturally at the heart of all interviews and was a prominent term used in the document that was included in the analysis. All participants regardless of status (strategic stakeholders, frontline professionals, volunteers and mothers) discussed their understanding of community and the assets within it. Strategic stakeholders discussed community in the context of the community-centred approach that they were familiar with because of the nature of their job. Frontline professionals largely understood community as a geographical area that they worked in but were not necessarily part of. Volunteers had a variety of perceptions regarding their understanding of and status within the community. Parents talked about the community as a place into which they were trying to integrate. The different perspectives on community form the first subtheme under this major theme and are presented next.

7.1.1. Perspectives on community

Generally, community was understood by professional staff from the VCSE, health and the public sectors in terms of its **needs and deficiencies**. The ward's deprivation data, unhealthy behaviours and low educational outcomes were often cited as the main characteristics of the community. Document analysis corroborated this, as a breadth of statistics ~~were~~ was given to describe the local community, accompanied with a promise that the community would be consulted on its needs in order to ensure that the programme targeted the people who needed it the most.

> *"I strongly suspect, the post-industrial indigenous culture of the Town Centre of Stockton involves alcohol, drugs, you know, domestic abuse, smoking" (Strategic Stakeholder D)*

> *"We will work with communities and partner agencies to increase our understanding of local need and to ensure that our services are targeted to those who need them the most and geared towards improving priority outcomes such as: explicit, focused and effective actions to narrow the gap in EYFS profile and improving life chances through increasing breastfeeding prevalence, nurturing pre and post birth." (Service specification document)*

Indeed, it was emphasised that the local community was disadvantaged and needed stronger support networks in order to become an "intelligent" community. "Intelligence" in this context was linked to the individuals' ability to seek and provide advice particularly around health issues. As the quote below illustrates, the debate between agency versus structure was central to some beliefs. It was suggested that, overall, disadvantaged communities tend to make bad decisions with regards to health and wellbeing, not because they are incapable of making good decisions (agency) but because the community's structures do not allow for such decisions to be made.

> *"And intelligent communities know how to seek and give good advice based on a natural set of relationships found within that community rather than the public services that exist in there. And those (relationships) will be needed particularly in more disadvantaged communities. It's disadvantaged communities that often take the worst decisions, not because they're evil people, not because they're bad, it's just what they do." (Strategic Stakeholder D)*

Community, for a number of professional participants, was understood as a set of relationships that exist between individuals and which are utilised when help is needed.

> *"I have an absolute firm contention, and nobody can dissuade me of this, that everybody seeks advice when they think they need it, everybody. It's just some people seek bad advice, but they don't realise it's bad advice. So, they will go to their friend and say, oh my God, I'm pregnant and my boyfriend's beating me up and they say, oh well you know what he's like, let's go and have a drink" (Strategic Stakeholder D)*

Some participants talked about communities within communities. That is, they differentiated between communities in which White British people reside and communities in which asylum seekers and refugees live, despite the fact that geographically, these communities were part of the same ward of the case study.

> *"Absolutely, we're talking about the Albanian community, we're also talking about the Muslim community, thinking about their need, again a very, very different need." (Early Years professional F)*

In addition, strategic stakeholders and frontline professionals referred to the local community as being separate from their own community. Despite the fact they worked with local people from the ward of the case study, they talked about community as an entity that does not involve or include them. They asserted that professionals' work ("us") would help the local community ("them").

> *"There are groups who are perhaps the people that we need to engage with the most, to make sure that they are empowered and supported to look after their children, who are not accessing services." (Strategic Stakeholder P)*

Interestingly, this was consistent across some of the volunteers' accounts who also referred to the community as being separate from them. Volunteers felt that the community was "out there" and volunteers ("us") should be going out to the community ("them") to provide support. The way volunteers talked about themselves showed that they felt more closely related to professionals rather than the community. Furthermore, some of the notions around community and its deficiencies appeared to have cascaded down to volunteers, presumably from professionals whom they worked alongside or the training they received. Interestingly, this was the case for indigenous as well as newly settled volunteers.

"They don't have the understanding they should as a parent. And the role A Fairer Start will play, I think, it's immense. Maybe you look at it as a small percentage but I think it's an important percentage. If you make a difference to a small percentage of people it will give them the foundation for later life" (Volunteer H)

Many volunteers discussed their notions of community. Given that many of them had emigrated from different countries, it would not be unexpected for them to differentiate between the community they grew up in and the community of the case study. However, they talked about community as an entity that all people are part of, regardless of race, religion, language or geographical area. According to them, because people live in a community and not in isolation, supporting the community and working with its most vulnerable members is an obligation rather than a choice.

"From my teens, early teens we know the advantages and being part of the community: you see how important it is. It's not just the family. The wider community is your family and you have to be part of it, and you have to provide support wherever required, so I've been very active from childhood and that has sort of, you know, been more or less the centre of my life throughout. That's how my upbringing has been, so I've been very active." (Volunteer D)

For some volunteers, community was associated with religion rather than geographical area; Christian Catholic volunteers felt that the church was the basis for their community. This was consistent for volunteers who had moved from their home country; they found a community that they could be part of in the local church.

"When I arrived here, I automatically through the church again I already started volunteering. The church runs a project, a refugee and asylum seekers project at one of the local churches just using the venue…so I joined the church. I was a member as well." (Volunteer I)

It is worthy of note that only two volunteers referred to the Stockton Town Centre community as an entity they belong in, both of whom were indigenous; for the majority of volunteers the community was a geographical area that consisted of people needing help and support that they could provide.

> *"But coming here, I want to give something back to my community, you know, like, I've never had a job. I don't want you to judge me by this, but I've never had a job. All I've got is life experience., I've got nothing apart from that, because I'm a mum." (Volunteer B)*

These different notions provide an insight into how community in general but also the local community were perceived by participants in this study. It is an important finding for two reasons; firstly, it shows the plethora of interpretations of the term which in turn emphasises the well-known and documented difficulty in a shared understanding. Secondly, it highlights that because of the lack of shared understanding in this case study, it is possible that participants' accounts were not necessarily about the same community.

7.1.2. Community assets

Inevitably for a case study exploring the use of a community-centred approach to public health, participants discussed the assets that exist in the local community. For some children centres' participants, assets were defined as the social capital that local individuals possess that can be harnessed (although this was not the language they used). It was felt that the networks and relationships that exist in the community can be used to ensure that appropriate support networks develop.

> *"Generally when we're doing things in the communities in venues, we sell it as a Stay and Play so it's very informal. You know bring them along, we'll have a Stay and Play, they get to know the Champions, they get to trust them, build those relationships and then we can...we do deliver messages." (Strategic Stakeholder O)*

The idea of relying on social capital which already exists in a community was not new to many participants; according to them, this was how communities operated in the 1950s and 60s. The term "neighbourhood" was used as the definition of a concept that has been lost in modern communities. The recognition of assets through the use of community-centred approaches can help revive a neighbourhood which takes care of its members.

> *"There is this thing about leaving the legacy, which is that whilst professionals are no longer engaged or their engagement is reduced that you have those volunteers as community champions who those families have developed a relationship with and can go and get support whenever they want. And that's really modelled on when you were living here in the 50's and 60's. I would walk out my door and if I saw my neighbours curtains closed, I'd worry, I'd go and knock on the door and say, are you okay? We live in an environment now, a climate [where] that that doesn't happen, so that first sort of community level asset base is what we've lost. (Strategic Stakeholder B)*

Cultural capital was also mentioned by a number of participants as a valuable community asset. The ethnically diverse local community had a lot to offer, both in terms of knowledge and understanding of people from similar backgrounds, but, more importantly, in terms of their language. It was felt that individuals who were from a different country and therefore could speak foreign languages could support individuals new to the community and facilitate their integration.

> *"If you had somebody that spoke your language, it'd be fantastic. That for me, that immediately gets over that isolation and starts integrating you into that community." (Early Years Professional K)*

7.1.3. Community development

Community development was understood by many as an attempt to shift the current top-down approach to a bottom-up approach. It was felt that community development can be achieved when the community is listened to by strategic stakeholders who control funding. The community needs to be engaged as opposed to merely involved. Strategic stakeholders felt that the current approach of telling communities what they need is failing and therefore there is a real need to consult with individuals on their needs.

> *"You've got to get the things that are challenging the family right before you can tackle the other things that they're doing. … that public health [emphasis on] keep beating them over the head with a stick .. And that's the only way it will work, and you do it at their speed and you do it in a way that doesn't threaten them." (Strategic Stakeholder A)*

Others described community development in terms of how integrated individuals are into the community and how cohesive it is. Social isolation was mentioned as a barrier to community development, particularly for marginalised groups and vulnerable people. The development of social capital was paramount for some as it was felt that professionals cannot help individuals to integrate. Volunteers (local assets), however, can provide that support instead and act as mechanisms for integration and social cohesion.

> *"(Volunteers) They're going to hold their hand, they're going to be a friendly neighbour, we're going back to how communities were many, many years ago in this country, which helped you out in your own community. Absolutely not asking volunteers to go in and do interventions with families. We're asking volunteers to support their local community to help create community cohesion." (Early years professional H)*

Mothers alluded to the concept of social isolation as well, claiming that the programme helped them and their children to be more sociable, meet new people and receive information about

potential training. Although the concepts of social cohesion and integration are far more complex than the account above suggests, some mothers felt that having volunteers run sessions at the children's centre helped them and their children socialise.

> *"Actually especially for (children's names) they enjoy groups because every time being stuck in at home. And also I, when I come here I met different families, and interact with them. And sometimes good information about courses or like this." (Mother A)*

Some participants discussed previous initiatives which aimed to aid community development and compared those to this programme. They showed little confidence in whether the funding provided over the years has made a positive influence in developing the community and thought that a cultural shift amongst professionals was needed. According to those accounts, professionals needed to relinquish their control, involve and empower the community to be independent whilst professionals maintain a supportive role.

> *"I guess because I've been around in Stockton so long, I've seen so many funding initiatives, you know from European funding and Single Regeneration, City Challenge Taskforce where really this area was inundated with millions of pounds and it was on interventions and initiatives. And I'm not convinced. I think some made a difference, but I'm not convinced...so this was more about that cultural shift…" (Strategic Stakeholder J)*

Community development was also discussed in terms of the time that it takes to be achieved. There was a recognition that "politicians" and strategic stakeholders generally tend to want a "quick fix" approach that can be quickly embedded and restore the issues they identify. However, participants appreciated that community development is not a quick fix, particularly as it involves a culture change amongst professionals working within communities. It was felt that community development cannot be expected to be achieved in three years; it is a process that takes at least ten years before it can be assessed in terms of its impact.

"If the programme continues and the volunteers keep going I can see it being a cultural shift within the community so that this is just the normal, this is what happens…in fact, I think it may be actually generational before it makes a big impact. I think if we're asking for school age we've got to wait for these school children to be parents [and] that's [when it's] going to make a difference." (Early years professional I)

7.1.4. Summary

This theme provided a description of participants' accounts around community, assets and community development. Through the examination of interview data, document analysis and observations it became apparent that the term "community" was understood in a variety of different ways by different participants. This was the case for participants' notions of community in general but also of the local community. Professionals and volunteers alike discussed the local community as an entity separate to them, which needed their help and support in order to change. This further emphasises the need for a cultural shift towards community-centred approaches particularly for professionals. On the other hand, mothers talked about community as an entity that they would like to be part of but had not been able to integrate into at the time of data collection. More importantly, due to the lack of a shared understanding of the local community, it was unclear which community the programme aimed to help, support and develop.

In addition, and with regards to community assets, these were mainly understood in terms of the social capital (relationships and networks) and the cultural capital (ethnic diversity and language). Lastly, and despite the fact that community development was mentioned in a number of interviews and documents, a lack of understanding on what it is and how it works was apparent. Participants mentioned words such as cohesion, integration and development in relation to community without however, providing any intricate descriptions of how

development actually can be achieved or what mechanisms a volunteer programme needs to employ to have the desired impact upon a community.

7.2. Tackling professional stigma or diluting quality of services?

This is a theme of opposite and conflicting views; the views of professionals and volunteers towards the volunteer programme. One of the reasons for the design and implementation of the volunteer programme put forth by commissioners was that professionals have "a certain stigma" attached to them that can only be tackled through the use of volunteers. That "stigma" however was thought to be non-existent by professionals themselves as well as mothers. Health professionals felt that the only purpose of the volunteer programme was to create a "cheap alternative" to public service demand, thus diluting quality. In essence, this theme is about the different notions of professionalism and volunteering depending on an individuals' point of view.

Perhaps understandably given the context mentioned in section 6.2, many professionals' attitudes towards volunteers were negative. The notion of professionalism was discussed at length during interviews with many asserting that the work of professionals cannot be replaced adequately by volunteers and therefore volunteers should not be used. There were professionals who were open to the idea of working with volunteers but discussed the necessary boundaries that need to be in place for effective monitoring. Interestingly, there were some participants who felt that volunteer involvement is essential in early years and in fact, in public health. However, these were professionals that were not required to work alongside volunteers and therefore were not threatened by them. Most importantly, in a volunteer programme that was established for three consecutive years and was fundamental to a pilot early years programme, it would be expected that the resistance shown by professionals would have improved over time, the initial barriers would have been overcome and the interaction between professionals

and volunteers would potentially lead to enablement. One of the most important findings in this theme was the profound lack of enablement of volunteers throughout the programme; that is, professionals never enabled the involvement of volunteers in their work and never enabled volunteers to work with families.

7.2.1. Resistance

The perceived "stigma" associated with health and social care professionals was most commonly cited as the reason why volunteering in early years may be necessary. The stigma was explained in terms of the authority that social care professionals have to remove children from their families, should they feel concerned about their welfare. It was therefore felt that some families are wary of these professionals and avoid seeing them as much as possible. It was further explained that probably a far larger group of families feel threatened and intimidated by health and social care professionals generally and, in particular, feel judged about their ability to parent. This view was widely held, both by professionals with commissioning responsibilities at higher levels of management and, interestingly, and at the other end of the scale, by volunteers.

> *"The health visitors and Social Services, they have massive stigma behind them, but it's around working with that family and negotiating that...you're not automatically going to get your children taken away from you." (Early years professional K)*

However, frontline practitioners felt that this was not the case. Some admitted that the language and the way they talk to families might not be appropriate, which can lead to families not adhering to their advice, but they felt confident in their ability to engage with them. They thought that volunteers might help them adapt their language to families' needs and confirmed that there is a place for volunteers in the community, but talked about them as an extra resource that they could use if and when needed.

"And it's actually listening to their (families) voice because we might think as professionals, well you need to do this and promote breast feeding but actually maybe we've been saying it wrong all these years and actually it's about what the key is to get that person to breast feed, what is it that is the right key for that person. You've got the tool box as a professional of knowing why we promote it all but actually for the person who's sat in front of you it's to do that trigger. And now having the volunteers supporting us will be helpful." (Strategic Stakeholder G)

Children's centres' practitioners further asserted that the professional stigma exists and impedes the ability of a professional to engage with a family. Their experiences have led them to believe that families tend to disclose issues to volunteers and not professionals, as the fear of their children being placed into social care stops them from engaging properly.

"We've had it where a volunteer has been out to support a family and that family hasn't told the health visitor but has told the volunteer, has disclosed (an issue) to a volunteer. They didn't want the health visitor to know. I actually spoke to her myself and it was...she was frightened that Social Services would get involved through something previous that had happened." (Early years professional B)

Volunteers also felt that there is a stigma around professionals regardless of their occupation (health professionals, early years practitioners, social workers) which stops them from being able to engage with families at the same level that a volunteer could. "Resistance to authority figures" was also mentioned as a reason for low engagement with professionals. Volunteers explained that, in their experience, families are resistant to the idea of engaging with professionals out of fear of judgement or, in some cases, fear that they are not adequate parents. According to participants, volunteers can empathise with families, having been through similar situations, which families appreciate and respond to by engaging with them.

"I'm so down to earth, and I'm approachable and I'm hoping that they (families) will see that rather than thinking, 'oh you're a social worker; eff off'! Cos some of them do, some of them see you as a professional when I'm just there to help, I'm not there to criticise, I'm not there to judge…" (Volunteer G)

"That sort of resistance to authority figures, I saw that quite a bit, especially with younger people having babies, they were quite 'oh, I'm not being a good parent and they'll come and take my baby'." (Strategic Stakeholder A)

Curiously, however, from the mothers' perspectives in this study, professionals' stigma was not mentioned; in fact, they all appreciated professionals for the work they do. Moreover, according to some accounts, socially isolated mothers started attending children's centre sessions following the suggestions from health visitors.

"It's my Health Visitor come to my house, she's a very nice lady. And she say you can come to the Star Centre, anytime you come, welcome. And she give me information, and (she) come with me. I have met nice person, and too many ladies in here. I have Kurdish lady (friend), too many different, all friendly. It's now different for me, now hard for me because I, as I start speak English everyone friendly for me. I'm now look different for anyone. I love everyone!" (Mother B)

However, volunteers were perceived as being more active compared to professionals, mainly because they were more visible.

"I think volunteer people are more active. Because it's all volunteer people in this room rather than paid ones." (Mother A)

Generally, the stigma associated with professionals and the perceived ability of volunteers to engage at a different level and in a different way were offered as reasons for the existence and perceived effectiveness of the volunteer programme. It is worth noting that only participants

with vested interests in volunteering offered these views; that is, participants who had commissioned the programme, participants involved in the management of the programme and volunteers.

On the other hand, frontline professionals, particularly from health service backgrounds, showed little belief in the existence of professional stigma; they described their relationships with families as being good and robust and did not feel that they needed any support in developing them further. They also showed little belief in the effectiveness, and indeed need for involving volunteers in early years work. They described volunteers as a cheaper and inferior resource to professionals who, when used, can dilute the quality of service provision at the same time as putting families at risk.

> *"(Volunteering) It's just kind of taking our job and making it a, like partitioning it all off, and then making it like a voluntary work, which is going to completely dilute the quality, and possibly potentially not be as, as effective." (Early years professional D)*

The perceived threat to their own professionalism was very apparent in interviews as they talked about dilution of quality, partitioning of their roles and decreased effectiveness. In addition, they felt that the responsibilities suggested for volunteers meant that professional jobs were at risk. If volunteers were to deliver healthy eating and breastfeeding sessions and provide advice, then professionals' jobs are threatened. It was felt that a trained health professional's assessment of a family involves numerous observations that a volunteer would not be able to carry out; thus potential issues could be missed. This could lead to issues that go unnoticed which, in turn, puts the family at risk. Therefore, these professionals very strongly resisted the idea of working with volunteers, as it would mean that their professionalism is under threat.

"If somebody is going to come in and deliver healthy eating and deliver dental health education, all our little core, then what is our role? But then we don't just go in to ask about dental health. Our assessment is so holistic that we're noticing things that people haven't even thought of yet. The slightest thing, the slightest behaviour from a child, the slightest kind of reaction from a parent, and we - you know - analyse that, and a volunteer, they're not going to see what we see." (Early years professional E)

Those professionals thought that they have a good rapport with families which volunteers could jeopardise. Due to the time it takes to build rapport with families, particularly when they are vulnerable, it was felt that having "another person" going in (a volunteer) would pose a risk to that rapport. The idea that volunteers can support a family was also dismissed; according to some early years professional participants, families do not want "another person" to support them: they want the professional they have a relationship with to provide additional support (than statutory support already provided). Therefore, the view that funding for health visitors, psychologists or midwives would help families greatly was prominent; help that cannot be replaced by volunteers.

"Not to big myself up or something, but me going [into a family home] is something completely different to a volunteer. I think that we found that because if you're going in regularly then you build up that rapport, and the family don't particularly want another person in. They just want the same person helping more. I think we should do regular clinics, our own clinics, so then my families would come to see me. And that would save me time going to visit everybody and if they really wanted my help, my assistance then they'd come, they would come to see me." (Early years professional D)

This view was shared amongst professionals who, although believed that volunteering has a place in early years, felt that more professional support is necessary. They also warned of more issues regarding volunteers as opposed to professionals; the issues of accountability and

consistency. Professionals appeared to have little faith in accountability measures for volunteers, suggesting that professionals "have more to lose" and therefore have to act responsibly and account for their actions, whereas for volunteers this cannot be enforced or if it is, it has little effect on them. This is in part related to the management infrastructure that was mentioned earlier in this subtheme. During the interviews with professionals it became apparent that the established management infrastructure for the management and support of volunteers was not clear to some of them. More importantly, for those professionals who were aware of the infrastructure that had been put in place to monitor volunteers, there was a persistent lack of faith in its efficacy.

> *"I'm more worried about accountability and the outcomes we are achieving for children, I'm not saying there's no place for volunteering and support, but as well as proper support. And you know, people's circumstances change, and reliability and consistency is very important for our families, you know and if you can't offer them that, it's very difficult" (Early years professional G)*

> *"And then you get staff saying, well yes but if we (make a mistake) we lose our jobs, we lose our income, what do they (volunteers) lose?" (Early years professional H)*

The issue around consistency was part of the wider issue of turnover of volunteers. Although participants acknowledged that it is "the nature of the beast" and volunteer attrition is an inherent problem of volunteering, they did feel that inconsistency can impact on families. This was justified by explaining that engaging with a family is a long and fragile process: thus a volunteer leaving the programme could have a negative impact on the family as well as jeopardising the relationship built. In addition, it was suggested that families may appreciate the common ground they may have with volunteers (i.e. same nationality, language or experiences) but ultimately what they value most is consistency.

"Sometimes you can make it worse, because people…need consistency in what we're offering and if a volunteer is there for a little period of time and then they leave and a poor family, or child, or adult even, who already may have attachment issues has to experience another loss, it's another grieving process for them…then it takes the next person who comes in twice as hard and as long to work." (Early years professional C)

"She [volunteer] had personal experience. I don't have personal experience, but I was consistent in those sessions from September until December. So you do build a relationship up with those who come, although unfortunately sometimes, some weeks, it wasn't the families that we needed to be in. But yeah, like you say, consistency." (Early years professional H)

The resistance shown by professionals towards working with volunteers and the concept of volunteering in general was apparent throughout the interviews for the reasons that were outlined above. However, volunteers had a completely different view to that of professionals. Firstly, volunteers understood their role as supportive, providing help to professionals as needed. They showed no intention to undertake jobs that they were not qualified or trained for; their main goal was to help professionals. In fact, some volunteers discussed how volunteering in the programme was a way to give back to professionals. They felt they had benefitted in the past from the support of health visitors and midwives when they were pregnant/post-partum and therefore volunteering in the programme was a way of showing appreciation and gratitude.

"All I thought about was that I'd had these home visitors come and see me, and help me out with my eldest because he was always running around. And the only way I could look at it was... it was that I wanted to give something back. They'd given me a lot of help, why don't I volunteer for them?" (Volunteer B)

The subtheme illustrated the resistance that was shown by professionals towards working with volunteers and the different outlooks on volunteering in early years. All of the reasons will be discussed in detail and interrogated against previous research in the final chapter of the thesis.

7.2.2. Boundaries

Another major theme that was developed from analysing the data was around professional boundaries, with many strong but diverse views. Some argued that the boundaries can be blurred and that volunteers should be working with professionals and share responsibilities for families. In order for this to be achieved, it was felt that volunteers need to be credible to both families and professionals whilst at the same time not over-professionalised. Interestingly, strategic stakeholders were perfectly aware of the issues of resistance from frontline professionals towards volunteers and felt that steps were being taken in order to address the issue.

> *"I think health visitors feel that they ultimately bear responsibility for the care for that family. So I think they maybe a little bit more cautious surrounding involving the volunteers. And what we've wanted to do is make sure that the volunteers are credible, have that credibility to families but also to the professionals, because sometimes they are the block there. Until a sort of closeness develops between the professionals and the volunteers, I think there will always be a barrier there. We are trying to encourage that; facilitate that through, you know, network meetings, whilst at the same time trying not to over professionalise the volunteers." (Strategic Stakeholder N)*

Although the term "over-professionalise" was used by a number of participants in relation to volunteers, it was never fully described. For some it meant that if the volunteers received the same or similar training as professionals they would inevitably use the same language or terminology which would mean that a family would see them as another professional.

The term credibility was also used in many cases as a synonym to the word professionalism. Some adopted the view that credible volunteers (described as "of the same standard as professionals") would be preferable to volunteers who are less credible. However, some

disagreed with this view as they felt that volunteers can never be of the same standard as a professional.

> *"I don't mean to sound snobbish, but to get them to a standard where, for them to have the same standards as what we have if we are not there (wouldn't be possible)." (Early years professional D)*

Others asserted that working with volunteers involves inherent issues, particularly when working with local volunteers. These were issues around confidentiality, especially when health and social care services are involved. As volunteers are part of the local community and might live next door to families they are supporting, they might disclose confidential information to them. The role of management was again emphasised as the only mechanism that could instil faith in professionals. Many expressed the view that involving volunteers in working with a family is risky, citing their duty of care to the family as a reason for this.

> *"It's maybe just not knowing what safety nets are in place. If they did have a volunteer who was overstepping boundaries, would anyone realise that, if they would find out a lot of information about a family and [were] gossiping about it? Where are the supervision and where's the monitoring things? And unless I knew what was happening with that, I would be very careful about how I would use a volunteer, because my duty of care would be to the child I'm working with and as an extension to their family. So I would only get someone involved if I was sure that they were going to do the right thing by that family; I wouldn't risk it." (Early years professional G)*

Crossing boundaries was also discussed in relation to reputational and professional damage that a professional can suffer as a result of involving a volunteer in their work. Professionals felt uncomfortable suggesting volunteer involvement to a family as they thought that this would put their professional reputation on the line in the case that the family disliked the volunteer.

However, this was described as an issue which only affected volunteers; that is, no explanation was offered as to what would happen if a family did not like a professional. Assumptions around the likability of volunteers and their (in)ability to engage with families were therefore apparent.

> *"Especially if they are a little bit reluctant, and do you know that's the people that we need to be seeing, the reluctant ones. That's who we're targeting really isn't it? So if I manage to get her to sign the form or whatever, and then you know then somebody comes and she doesn't really get on with them, then we've lost them. I've lost my credibility really" (Early years professional D)*

The boundaries between professionals and volunteers were much clearer from the volunteers' point of view. Their accounts consistently stated that their work was different, albeit complementary to that of professionals. Volunteers who got the chance to work closely with health visitors during the course of the programme were inspired to pursue a career in health services despite the fact that it meant retraining and going back to university.

> *"Well for now I will just wait for a couple of months and then once my daughter starts full-time nursery next year, that's when I will think of going back to university to do my nursing...but this experience is definitely going to help me because when I put it down on my CV and they will see that I have already done something with a health visitor…" (Volunteer I)*

In addition, volunteers acknowledged that they cannot replace professionals. In fact, most volunteers reported consulting professionals for advice regarding their own families rather than talking to other volunteers. This indicates a clear understanding of the boundaries and the limits of volunteering. Volunteers stated that they can support professionals in facilitating engagement with families, but made no claims that they have the expertise needed to replace professionals.

"I think they're more professional, health visitors, they can explain more to people because they have experience, so I personally prefer (talking to) a professional like a midwife. They have more experience; they can explain more than, like, a volunteer." (Volunteer E)

Nevertheless, they also mentioned that if a volunteer was available to help them at the time they needed it, they would have been more likely to engage.

"If this (a volunteer), if I had this back then, I mean my mental state might not have took it but it would have been good for me. I think when I do these visits, I want people to see that I'm there to help before it gets bad, you know?" (Volunteer G)

7.2.3. (Lack of) Enablement

This subtheme was developed as a result of the lack of data rather than their presence. During a number of interviews participants offered suggestions as to how volunteers and professionals could work together. They discussed how volunteers could enable over-worked professionals to perform their roles easily and more effectively. Volunteers were seen as an extra resource for professionals to utilise in order to support families. Given the limited time that professionals have with their clients, they are also limited as to the support they can provide. Having a volunteer working alongside them could mean that a family receives better services and is supported holistically.

"So we're coming at it from that child, but also that family as a whole, a whole unit, so very much that holistic approach to family health and wellbeing. To knock down those barriers, to myth bust, to get that child where they need to be so...For instance, if there is a family that's new to the area and they don't know what's out there and may be a little bit isolated and don't really want to access any services, the health visitor can have a chat with that family and think, oh actually they might do with a buddy." (Strategic Stakeholder O)

Other examples provided by participants included professionals using volunteers as translators/interpreters, administration assistants and befrienders. Despite the undoubted good will of these participants however, enablement never happened. Some of the reasons for the lack of enablement have been analysed earlier in this chapter (accountability issues, quality issues and others). Additional explanations as to why utilising volunteer resource was unfeasible included professional constraints and structures (health visitors and midwives can only use interpreters from NHS-approved agencies due to safeguarding and confidentiality policies) and lack of faith in the effectiveness of the process.

These findings were corroborated during observations where no interaction between professionals and volunteers was observed. Volunteers were based in children's centres waiting areas where they could interact and speak to families but had no involvement or working relationship with the professionals working in the same building. On occasions where professionals wanted to refer someone for additional support, an early years professional within the centre was sought rather than a volunteer.

However, during the interviews, professionals discussed how they had utilised volunteers at the beginning of the volunteer programme which had worked very well for families as well as the volunteer, but for unknown -to them- reasons that volunteer support was pulled and was never replaced.

> *"She (the volunteer) was amazing. Whether that had been because she'd gone through the same path as those families were going through, so she had it from a personal point of view. But she made that commitment. She attended every Monday didn't she without fail? And she then went and managed to get all the volunteers to attend another session on a Saturday. Which was immense. It was like how on earth are you getting to do that? And then, for whatever reason, it be political, or it be whatever else, she got pulled from it." (Early years professional H)*

This was substantiated by the volunteer who had provided that support, who explained the reasons behind the decision; due to the fact that the work was carried out through a different children's centre and because the hostel where the work was taking place was outside of the boundary of the programme, she had to stop.

> *"it was difficult to get started with them (professionals) because most of the health visitors and the midwives are at the (children's centre A). So (team leader) was kind enough to take me there and I actually started to go to one of the hostels every Monday for six months. I went with them, got in touch with what they were doing, the routine work, and what kind of issues people have with living in a hostel and those kind of concerns people would bring….And uh...and then...every month we would do a drop in for them at the family hub and myself and my husband we both were given the role of looking after those projects and we were given the title of Ambassadors for these projects. And then in January it was decided that (I should stop)... because all what I was doing was...the credit was going to the (children's centre A), because A Fairer Start has a boundary. So the credit was going to them and location wise...although this centre was doing it, the credit was going there. So they said we need to be within our boundaries." (Volunteer I)*

It can be argued that in a newly established volunteer programme that faces the issues described earlier in this chapter, such situations can be detrimental to its reputation and indeed its success. Given the small geographical area that the programme was implemented in, and the fact that most professionals in the area had pre-existing networks and relationships, it is logical to assume that reputational damage to the volunteer programme due to "word of mouth" is possible. Therefore, the observed and documented lack of enablement can, to an extent, be understood in this context. Unfortunately, enablement of volunteers to work alongside professionals never happened throughout the programme's existence.

7.2.4. Summary

This theme illustrated the tensions and sensitivities that were apparent in the volunteer programme. It has showcased the profound resistance of professionals to working with volunteers, the worries around the professional boundaries and the lack of enablement of volunteers' work, despite strategic stakeholders' best efforts. Perhaps the absence of a clear theory of change in which the roles and responsibilities of professionals and the roles and responsibilities were clearly outlined as well as the fact that, despite initial thoughts, volunteers and professionals never interacted or trained together, led to the volunteers never being accepted by professionals. The interpretation of findings in the discussion chapter will analyse the issues of resistance, ~~professionals~~ boundaries and lack of enablement at more length.

7.3. Volunteers in early years: missionaries, grassroots workers or selfish people?

The last theme that was developed through analysis was around volunteering in early years, the differing expectations and realities of the volunteer's role as well as the impact of volunteering on volunteers. This theme encapsulates, similarly to previous themes presented, the conflicting and inconsistent ideas put forth by participants around volunteering in early years. Discussions focussed on the ideal person to volunteer in early years (expectations), the person that actually volunteers in early years and the motivations/reasons behind their work (reality) and the value that volunteering activities in early years can produce for volunteers.

7.3.1. The ideal volunteer- the missionary

The characteristics, behaviours and skills that the ideal volunteer should possess were discussed at length throughout interviews. As presented in section 4.5.4, the document outlining the volunteer programme stated that individuals with the following characteristics would be actively sought:

- the unemployed
- retired professionals with life experience
- parents with children in school and day-care
- BME individuals
- individuals with experience of mental health issues and substance misuse,
- people with an early years background
- individuals who are well known in the local community within Stockton
- older people (grandparents) with community and or family standing. (Butler, 2015)

This exhaustive list of target volunteers shows that one of the aims of the programme was to recruit people who could benefit from it in terms of developing their social, personal or cultural capital. Although not explicitly stated, targeting the unemployed and BME individuals suggests that the volunteer programme might help them secure employment and develop links with the local community. Aside from the people who would benefit from the programme, the focus was also on people who would also benefit the programme by offering their "life experiences", their experiences of mental health and substance misuse issues, or their "standing" whether in the community or the family. Again, no explicit explanation was given as to what constitutes life experience or community and family standing or how these were assessed. Interview data provided some insight into the characteristics that a volunteer would ideally possess.

The "right" volunteers therefore should have numerous and diverse personal experiences from having left school at age 16 to having had involvement with social services. Volunteers with those experiences should get some work experience and get everything "they need" to improve their lives. In contrast, and although retired professionals would also be welcome as volunteers, they were thought as potentially being resistant to change due to their pre-existing attitudes.

"I would like people who've got qualifications, and a lot of experience, smashing, great because they bring something to it. But I also want the people who didn't do very well at school, who feel like they're on the scrapheap. I want to bring them in and say, come on we'll give you some work experience. We'll give you on a plate all those things that you need to take to move on and improve your own life. And some of it goes back to the cultures, behaviours and skills because you could have someone who's been a previous health visitor or something and you might think, oh my god, because their attitude is still in the old school ways." (Strategic Stakeholder J)

There are several statements that need to be unpicked form this quote and the interviews that put forth similar views. There was a widespread assumption that people who left school at age 16 or did not go to university were worse off compared to people who did, and that taking part in the volunteer programme would give them the support and help they needed to improve their lives. The use of the word "improve" shows, to some extent, the prejudices that existed towards volunteers before they were even recruited.

The second interesting finding which is evident in the above quote is that judgemental attitudes existed towards professionals as well, whether that meant people with qualifications or experience in early years work. They were perceived as having attitudes that did not fit the new system ("old school attitudes") and thus would be difficult to work within the volunteer programme. This is particularly interesting as these attitudes were held by strategic stakeholders who, although had strong opinions as to who the volunteers should be and what attitudes professionals needed to change, simultaneously disassociated themselves from the volunteer programme and the community as a whole, and did not feel that they needed to change/adapt in any way.

The experiences that local volunteers had which, presumably were similar to those of the targeted community, were the main point that differentiated them from professionals. The

assumption that professionals lacked experiences which the community could relate to was prominent.

> *"What we don't have as professionals is that real grass roots local knowledge, life experience and being able to engage at that level. So, volunteers who live in the community, who've had similar life experiences, know the community, will be able to engage a lot more because as a professional you already establish barriers." (Early years professional E)*

The notion that professionals cannot engage with the community at the level that volunteers can was used by many as a justification for the volunteer programme. The "grass roots local knowledge" that volunteers have was knowledge which professionals used to have but has been lost due to the fact that the public sector became "risk averse" and introduced safeguarding measures that restricted professionals in engaging with families the way they used to. Volunteers therefore could repair some of this relationship dysfunction by talking to professionals.

> *"And then what we did was, we put that additional layer in because of safeguarding and because everyone is a bit risk averse, of thinking, oh we can't let local people do this because what if and what if that happens? And we look at liability and being taken to court, so all of a sudden we'd become very distant from the community so we've lost a bit of that. So the only thing we know about what's going on in the community is if we happen to have people who talk." (Strategic Stakeholder J)*

The notion that volunteers should be gathering intelligence and reporting back to professionals was very prominent amongst strategic stakeholders. Volunteers, having received training from professionals, would be able to identify peers who need support above and beyond universal service provision and would be able to refer people to receive additional help. Volunteers were also seen as missionaries; trained individuals going out in the community to "convert" them to

a healthier lifestyle, promote engagement with services and feed information back to professionals and statutory services.

> *"I always feel it's a bit like missionaries years ago, and they go off to convert them, I sort of think there's a touch of that." (Strategic Stakeholder J)*

The "missionaries" would be the "eyes and ears" of the community, would speak the language of the community but would be trusted by both local people and professionals and could act almost as brokers between them. By utilising volunteers, broken relationships could be restored; trust in health and social care services could be re-gained.

> *"We want them to be proper grassroots workers but it's building that sort of knowledge up with the professionals that actually that is something that's desirable and that yeah people (volunteers) might not use the same language as you, but that's a good thing actually." (Strategic Stakeholder B)*

However, a view on this notion of sending missionaries into communities is that of surveillance. The wealth of information that professionals (therefore statutory services and therefore the state) can receive from volunteers in the community was used as an argument for the need of volunteering throughout the interviews.

To summarise this subtheme, there were several expectations (i.e. hopes) around who the ideal volunteers would be, what characteristics they would possess that would facilitate their purpose; gathering intelligence on the community. Generally, it was felt that volunteers have life experiences that the community can relate to as opposed to professionals who, restricted by safeguarding measures, have lost the ability to engage with the community. The ideal volunteers were, to an extent, people who had not been successful at school/university/work and therefore would benefit from the volunteer programme. The volunteer programme would offer them the opportunity to get everything they need to improve their lives in exchange for

information and intelligence on the community, which the professionals need. These were the expectations for the programme and its volunteers; the reality however, was quite different.

7.3.2. The early years volunteer in Stockton

Based on the volunteers who took part in this study, the characteristics that the programme aimed to have amongst the volunteer workforce were present. Most volunteers were unemployed, from a BME background and had children of school age. Out of the volunteers who were not from a BME background, one had experiences of mental health issues and one was a grandparent.

Therefore, as far as the desired characteristics and expectations are concerned, from the strategic stakeholders' point of view, the recruited volunteers were the desired volunteers. However, the interviews with volunteers showed that their perspectives around their role and purpose was very different to those of strategic stakeholders.

Whilst gathering community intelligence was predominantly a role that strategic stakeholders thought volunteers could assume, none of the volunteers mentioned it in their interviews. Although they talked extensively about the community and their role within it, reporting the information they gather back to professionals was never discussed or suggested by any of them. The reasons behind this are unclear; it could be because community surveillance, intelligence gathering and reporting were never explicitly part of their role description or because intelligence gathering was never possible due to lack of engagement from the community or because volunteers disagreed with the whole concept.

Volunteer work was part of some volunteers' lives before signing up to this programme, with some having previously taken part in religion-based volunteering or activist volunteering. As far as the reasons to volunteer were concerned, the desire to "give something back" was

commonly cited. The quotes presented illustrate that for some, volunteering was not an option but rather a responsibility. This is not to mean coercion to volunteer; it means that volunteering was understood as part of civic life, as something that people ought to do.

> *"You can imagine it's quite difficult and coming from the set up that we have back home, family life is quite intricate, it's very important, and we never expected we would be in a situation where we started a family and we don't have our family around us. So to be put in that position even then that wasn't...there was no decision to be taken…we understand the whole concept of volunteering what are the benefits, and you know we knew that it would all fall into place." (Volunteer I)*

The notion of reciprocity as a response to the support that volunteers had previously received was apparent. As new parents in Stockton or as newly settled asylum seekers, volunteers felt that the help they received was overwhelming, which enhanced their desire to reciprocate.

> *"(Volunteering) is good; it's very good you can help someone. Because too many people helped me, in the church and in the (children's) centre. Too many (people) cared and I want to help someone because too many people helped me." (Volunteer H)*

It could be argued therefore, although not explicitly stated, that the idea of volunteers as missionaries is quite opposite to the idea of volunteers as community/family workers who feel obliged to the community and its members. Therefore, it is plausible that the differences in notions on community and the role of volunteering within it are part of the reasons for the fact that intelligence was never gathered and reported back by volunteers.

On the other hand, and although volunteers strongly suggested that their role was to give back to the community by providing support, which can be seen as having purely altruistic intentions and motivations, their accounts also revealed contextual circumstances that influenced their decision to volunteer.

Six participants had been asylum seekers for over 7 years at the time of the interviews, which they described as a long process which prevented them from having a "normal" life. Having the right to work was seen as a privilege that UK citizens have and which they were lacking. This was described as "unfortunate", particularly given the fact that all volunteers expressed their willingness to work and contribute to the UK economy.

> *"It's unfortunate, because it's hard to see things clearly from my perspective. The situation that I'm in, being an asylum seeker and not having the privileges as a normal person has in this country…" (Volunteer D)*

> *"That's the one thing that I just want to exercise my rights because I want to work. And because I'm able, I'm still able to work." (Volunteer C)*

For asylum seekers, the fact that they were qualified professionals in their home countries yet were refused the right to work in the UK was a point of discussion. Their reports showed a difficulty in accepting unemployment, particularly because they had working lives prior to fleeing their countries. Professions ranged from teachers, social workers and nurses to recruitment consultants and computer specialists. Moreover, this was an issue for mothers who also felt the need to work in the UK having had a professional background in their home countries.

> *"Yeah because I want to do something, well it's been 7 years and I did my computer sciences back home so I was a computer teacher and I had a job and unfortunately we had to leave." (Mother C)*

The willingness to work appeared to be very strong amongst asylum seekers; so much so that mental health issues were reported as a result of unemployment and lack of ability to provide for their children; a situation made worse by the fact that their children want the lifestyle of their peers at school. This was present in interviews with both volunteers and mothers.

"Still I come here (UK) and I'm not allowed job. I come here I'm not allowed school. I come here I'm not allowed car, not allowed this, not allowed this, not allowed this, I feel sad again. People try to burn me, people try to frighten me as well. I don't know, I'm not a lucky person." (Mother B)

It is of particular interest that despite these difficult circumstances, during these discussions volunteers emphasised their appreciation of the help they received from the community and their willingness to reciprocate this help, even when they enter full time employment.

"Yeah I will look for a job. I want to do nice stuff for my family. I want to volunteer as well to help people, because I will never forget that someone helped me." (Volunteer F)

Aside from issues specific to asylum seeking volunteers, all volunteers had been out of work for some time, which resulted in a lot of them feeling insecure and unable to find a job. Amongst the reasons reported for the years of unemployment were mental health issues which prevented volunteers from full time work and raising children without a partner. However, all but one volunteer had extensive previous work experience either in their home countries or in the UK.

"So...having the background of working professionally back home, a decade's time of experience we couldn't sit around doing nothing me and my wife so we decided to look at the possibility of...we heard about A Fairer Start and volunteering and all of that and we decided to enrol ourselves for the volunteering programme." (Volunteer D)

Others discussed how past experiences of involvement with Health and Social Care Services led them to think about others who are in similar situations and felt that they should help.

> *"I love it because I can relate very much to it, I had a daughter at 16 and social services wanted me to use all these different services and I wasn't a willing participant back then so I can relate very much to why they might not answer the phone, situations at home, you know." (Volunteer G)*

This subtheme aimed to illustrate how volunteers themselves saw their role and the strong sense of reciprocity they exhibited. Contrary to the previous subtheme which described volunteers as missionaries; informants that work alongside professionals and act as brokers between services and the community, here volunteers discussed how the community is their family; a family they have benefitted from previously and now ought to support. Although for many volunteers their circumstances meant that they could not secure employment, which was not ideal, they talked fondly about the community and showed no intention to assume a "missionary's" role.

7.3.3. Grass roots workers or selfish people?

This third and final subtheme interrogates interview data which are in conflict with previous subthemes. Although the notions of reciprocity, giving back to the community and altruism were prominent in the last subtheme, both volunteers' and professionals' accounts included notions of personal benefits to volunteers.

When asked, volunteers' main motivation to volunteer appeared to be reciprocity. However, volunteering was also understood as a way into working life. For some, volunteering was seen as the beginning of a career in an area that they could relate to and could understand better, having had problems as new parents themselves. For others who had years of experience in different areas of work, volunteering was their opportunity for a career change in an attempt to increase job satisfaction.

"Because I would have just carried on, I'd have found another job in retail and just plodded along and I don't think you ever get any satisfaction out of it really. I get a sense of achievement here [laughter]. It's like; yes I've done that today." (Volunteer B)

For volunteers who were, at the time of the interviews, seeking asylum in the UK, volunteering was an activity which could provide them with work experience in the country. This was understood as both the experience needed for potential future employers who expect continuation of work, as well as experience in working life in the UK which could help them in filling in job applications and understand what is expected of them as employees. Similar notions were found in mothers' accounts who were also seeking asylum at the time of the interviews.

"So, and now I have started doing the job club, they give you some more advice, they get you ready for your interview and writing your CV so you can get (a job here)" (Volunteer I)

"Actually you know, we are not in my visa status, we are not allowed to work yet. Not yet.

I: Are you seeking asylum?

R: Yeah because after soon I'll have our papers because for my son based it's nearly seven years here. Then maybe we get our papers very soon…And that is why I engage myself in this because I you know wanted to do the Teaching Assistant course." (Mother A)

With regards to specific aspirations that volunteers reported, careers in catering and hospitality were preferred. Interestingly, this was associated with early years work such as working in schools or nurseries' kitchens. For some, a career in children's social care was seen as more appropriate based on their previous experiences and qualifications. Careers in teaching in primary or secondary schools were also popular amongst volunteers. Lastly, having worked with children, some volunteers wanted to explore careers working with different age groups (i.e. the elderly).

Interestingly, for some participants volunteering was merely "something to do" with no expectations or aspirations that it will lead to a job, and reciprocation was the main reason to volunteer. In addition, some volunteers were happy with having a part time job and volunteer in their free time, thus suggesting that reciprocity was the only motivation to volunteer. Most volunteers however, aspired to obtain full or part time employment through their volunteering.

In addition to volunteering being seen as a way into paid employment, it also provided volunteers with personal development opportunities. In the beginning of the volunteer journey all volunteers completed personal development plans. As part of those, volunteers chose five areas that they would like to improve on as well as areas within early years that they would like to explore. This development plan, which was revisited on a monthly basis during supervisions, documented the volunteer journey in such a way that the progress was visible both to volunteer coordinators/supervisors and volunteers themselves. Volunteers appreciated this, as it gave them flexibility in choosing different areas of work and, as a result, they continued volunteering even when some of the activities were challenging for them. For example, some mentioned that when they first started volunteering their confidence was particularly low, which meant that they were not comfortable with conducting family visits; they preferred to work in the children's centre amongst staff members. Once their confidence was improved, they felt that they could explore other areas of work including outreach.

> *"You could be sent to (outreach work), and at the time I had a massive anxiety disorder so it was a no-no for me at that time. So, I just stayed within the vicinity that I was comfortable. Eventually I went, but I needed time." (Volunteer C)*

Many volunteers reported feeling insecure, shy and nervous when they started volunteering but felt that their confidence and self-esteem increased as time went on.

"So I was a bit scared to go somewhere else, a different centre. I was a bit scared, I was shy, I didn't know people, how can I manage, how can I be comfortable but now I think I can go anywhere they send me." (Volunteer C)

"And it builds your friends up, it builds your knowledge up and if it makes you a happier person for it then why not?" (Volunteer F)

Some volunteers, particularly asylum seekers, also suggested that volunteering helped them overcome mental health issues, as before they volunteered they had been socially isolated and depressed. Volunteering gave them a reason to leave their houses, become active in their community, which resulted in them forging friendships and thus reducing social isolation.

"Because I'd been married about eight and a half years and I don't have any children so I was just sad, it was a really hard time for me. So, slowly, slowly I was just building my confidence and I met different people so I made some different friends as well." (Volunteer H)

The development plans also served the purpose of focusing volunteers on the career path they would like to pursue. For volunteers who wanted to follow a career which required college or university qualifications, the organisation supported them in the enrolment process for relevant courses and helped them find placements as needed. For volunteers whose first language was not English and had not been through the UK education system, courses in English and Maths were provided by the organisation in preparation for college or university.

"I'm also doing college as well, which actually (organisation) put me on, health and social care on a Wednesday, only part time so I'll get that qualification out of the way while I'm volunteering. I'm taking the training that they (organisation) offer as well, speech and language, healthy living, anything really, you get a certificate out of it so…I'm going to build up a portfolio out of my training and just see what I've got, I can't think ahead too far ahead, I am where I am now and it took me a long time to get here so while I'm here I'm just comfortable." (Volunteer G)

In terms of support to secure employment, volunteers reported that they received help in filling in job applications and preparing for interviews. Interestingly, volunteer coordinators in the programme felt that all volunteers would be valuable staff members and therefore were trying to secure employment for them within the children's centres.

Similarly, volunteering was an opportunity to explore areas of work in early years, having previously worked in different areas (e.g. retail or customer service). Perhaps more importantly, it provided volunteers with the flexibility to combine work experience with caring for their young children, at the same time as increasing their confidence.

"And then...so by the time I'd finished all my courses, he (child) was only going to school nursery, and what I didn't want to do was to say I'll come to work, but I have to leave at quarter past eleven. I couldn't do that. I couldn't work in crèche that's meant to be half nine until half past eleven when I had to leave at quarter past because I didn't think that was fair on my colleagues. So I just decided...I said the best thing for me to do is to do it voluntarily." (Volunteer B)

Interestingly, as the quote reveals, volunteering was also seen as a way of working and supporting service provision without the constraints that a professional job entails (i.e. working set hours). Ensuring that the flexibility needed for a single mother did not interfere with the service provided and professionals' work was a priority for volunteers.

7.3.4. Summary

This theme showed how different perspectives coexisted amongst participants. There were different views on who the volunteers should be and what their role should look like compared to who they actually were and what their role actually looked like. Strategic stakeholders predominantly, felt that volunteers should be missionaries; brokers between professionals and the community. Volunteers should be the eyes and the ears of the community, know what the current issues are and report them to professionals in order to be acted upon. However, volunteers saw the community as a family and therefore saw their role as being supportive of the community. There was a consensus amongst volunteers that due to the fact that they had received support from the community, they ought to give something back, to reciprocate that help. Particularly given the fact that most of the volunteers did not have the right to work in the UK (due to the fact that they were seeking asylum in the UK), volunteering appeared to be the natural solution to their unemployment and willingness to work whilst providing them with flexibility to work around their childcare commitments. Although the benefits to volunteers were well reported (way into employment, increase confidence and self-esteem and access to courses), volunteers consistently showed altruistic intentions towards the community as well as professionals.

7.4. Chapter summary

The second findings chapter aimed to present the three major themes as developed following the analysis of interviews and observations. The diverse notions and understandings of the community were of particular importance because it showed that participants were unclear as to what community they tried to help, what its assets were and what its development would entail. This was the first fundamental problem with the volunteer programme.

The different views around professionalism and volunteering formed the second major theme of the study. Whether volunteering was considered to be the "cheap" alternative to paid work or a much needed shift in early years work, it was resisted by professionals, and never enabled. Partly due to the lack of clear boundaries, job insecurity or lack of faith in the approach altogether, opportunities for volunteers to work with professionals were rare.

The third major theme presented another problem for the programme; the lack of consensus on who the volunteers should be, who they were and the reasons for volunteering. The theme showed that there were expectations for volunteers to be missionaries, spying on the community and reporting back to professionals. This could not be further from what the volunteers understood their roles to be and the reasons behind their motivations to volunteer. Perhaps if those motivations had been shared with professionals, the programme would have resulted in different outcomes.

Chapters 6 and 7 presented the findings of the study without interpreting them; the final chapter of the thesis will provide an interpretation of the findings. In addition, the findings will be interrogated against previous literature and research as presented in the second and third chapters of the thesis. Lastly, the thesis will end by drawing conclusions and providing implications for theory, research and practice.

8. Chapter Eight: Discussion

The discussion chapter begins with a summary and interpretation of key findings. These are then contextualised and interrogated against the wider literature and previous research. Based on the interpretation of the findings and the learning from the literature and research, a practice model for developing and implementing community-centred approaches is presented and described. Some reflections on the research process are provided and the strengths and limitations of the study are discussed. This draws the chapter to a close before the last thesis chapter, the conclusion and implications of the study, is presented.

8.1. Summary and interpretation of key findings

The findings of this study can be broadly categorised into two main areas; the practicalities surrounding the operation of the FSVP and the intricacies of concepts within the community-centred approach it adopted. More specifically, the practicalities refer to the lack of shared understanding around what the FSVP was and what it was trying to achieve which led to the reality of its operation.

8.1.1. Expectations versus reality

A theory of change for the FSVP was never developed. Based on Fletcher's (1984) argument that a theory of change for any intervention or programme exists, even if it is not realised or shared amongst stakeholders, the FSVP's theory was developed as part of the findings of this study. The theory of change approach can be valuable when used before the development of a programme such as the FSVP as it can sharpen its planning and ensure that its activities have a purpose (Mackenzie and Blamey, 2005). Thus, using the approach retrospectively may be less helpful for the programme itself. However, it is still an important tool in understanding the intricacies of the programme and can inform future evaluation and research. Rippon and

South's (2017) theory of change for asset-based approaches was used as a tool with which to interrogate the findings. Its wording was adapted to include the totality of the community approach rather than asset-related activities in an attempt to capture the FSVP's scope which spanned beyond assets and aimed to aid community development. Rippon and South's (2017) theory of change was useful in ensuring that all the evidence gathered from the research was categorised against certain stages/expectations. Its adaptation allowed for a more in depth understanding of all programme activities and efforts without altering the theory in itself.

The importance of a theory of change is threefold; firstly, it provides a clear focus and a plan of what inputs and activities are required to achieve the desired outcomes. Secondly, it allows for replication of successful programmes in different settings (Nilsen, 2015). Thirdly, as Blamey and Mackenzie (2007) argue, a theory of change approach allows for a detailed understanding of the context in which an intervention or programme is implemented and how this context may influence and be influenced by the intervention or programme. The findings of this study argue that there is another important aspect to the development of a theory of change. It provides stakeholders with the opportunity to understand and be explicit about the assumptions that are made and which guide the programme.

As shown through the analysis of the data, several assumptions were implicitly made during the development of the FSVP. First, it was assumed that volunteering as an approach, could be successful in tackling the observed early years and public health issues in Stockton Town Centre. Secondly, it was assumed that early years professionals are sometimes unable to tackle those issues due to their lack of ability to engage with families. The third important assumption was that by training volunteers in public health and early years work, their confidence, employability and self-worth would improve, thus leading to individual as well as collective empowerment.

Those assumptions are noteworthy, not because they are inherently wrong or right but because their presence (implicit as it was) affected the way the FSVP was operationalised. Due to the fact that volunteering was presumed to be effective, little thought was given as to the infrastructure it needs, the potential issues and pitfalls that it can have. This meant that there no adequate plans for monitoring and reviewing practices, thus leading to a programme with few tangible outcomes that can be directly attributed to volunteers and volunteering in general. This issue around the impact of volunteers on outcomes has been identified in the literature around community-centred approaches and volunteering research (Johnson et al., 1993; Woodall et al., 2013). Johnson et al. (1993) were unable to attribute better nutrition outcomes for children to the involvement of volunteers (para-professionals) and Woodall et al. (2013) were unable to identify the impact of volunteers on health outcomes. The fact that the impact of the FSVP volunteers could not be identified was therefore unsurprising.

The assumption around the inability of professionals to engage with families, led to early years professionals feeling wrongly blamed and offended, thus leading to reluctance and sometimes refusal to work alongside the programme and its volunteers. Indeed, the strategic stakeholders of the programme in their attempt to improve professionals' and the community's relationship, inadvertently damaged those by creating negative feelings amongst the workforce. Although the friction and challenging relationships between professionals and volunteers has been noted in the literature (Netting et al., 2004), less attention has been given to the importance and influence that strategic stakeholders can have on those relationships. The findings around the blame frontline professionals faced from their superiors and the way they reacted to this blame are therefore important.

The last assumption around individual and community empowerment meant that little thought was given as to what empowerment means, how it is influenced and how it is measured. The

findings showed that although participants used the terms frequently, they were unable to describe how they occur and what mechanisms are involved. Indeed, the difficulty in defining and understanding terms such as empowerment and development in relation to communities has been previously identified (Green and Haines, 2015). However, the findings of this study show that this difficulty is common amongst strategic stakeholders who have responsibility for commissioning, designing and implementing community development and empowerment approaches and programmes. This has been neglected in the literature before despite the significant implications it can have for community-centred approaches.

Overall, the assumptions made throughout the FSVP cascaded down to all stakeholders involved in the programme. This is not an argument against making assumptions; it would be impossible to create a public health programme without assuming that an approach will be effective/ineffective. These findings argue that - had a theory of change been developed in co-production with all stakeholders - these assumptions would have been discussed and challenged (for example, frontline professionals would have had a chance to argue against the notion that they cannot engage with families) (White, 2009). Generally, the lack of co-production in the programme was at the root of the issues with its operationalisation.

Thus, the reality of what could be implemented as part of the FSVP was vastly different to the expectations. The envisaged plethora of volunteer roles could not be sustained partly due to the reluctance of professionals to accept volunteers as valuable resources. Despite the faith in volunteers and their perceived ability to engage with the community, lack of community engagement remained an issue. Attendance numbers were low throughout the programme, a fact which was never challenged by the programme's commissioners. This can be attributed to the assumption that volunteering is an effective way of engaging with the community and, even when this was not the case, the programme did not adapt. However, the support that was

provided for volunteers' development was adequate and supported them in their aspirations. Mothers also felt well supported and thought that their children were better integrated in the community as a result of their involvement in the FSVP. One could argue however, that these outcomes might have been achieved through mothers attending children's centres' sessions, regardless of the existence of the FSVP.

The lack of a theory of change was partly responsible for the way the programme worked in reality as opposed to the original vision. However, given the complexity of such programmes, the analysis of the data showed that the issues had deeper roots which are outlined in the following sections.

8.1.2. Community: "us" and "them"

The different notions about the term community were a pivotal finding of this PhD. Participants' accounts indicated little agreement as to what the community that the FSVP was trying to work with was. Many professionals felt that the community was separate to them, an entity that they were trying to help but were not part of. Interestingly, the majority of volunteers appeared to share this "us" versus "them" notion despite the fact that they were individuals from within the community. This emphasises the need for a cultural shift towards community-centred approaches as suggested by Kretzmann and McKnight (1993). Top-down approaches tend to reinforce the notion that professionals' role is to influence and help a problematic community, thus reinforcing the "us" as professionals versus "them" as the deficient community (Hopkins and Rippon, 2015). A shift towards community-centred approaches can alter these notions to include professionals within the community they work.

Some discussed the community in terms of its needs, whereas others saw it in terms of its diversity. Some focussed on the needs of certain communities within Stockton Town Centre

(asylum seekers, refugees, Muslim community etc.) whereas others discussed the White British community and its issues. However, mothers discussed community as an entity that they would like to be part of but had not been able to integrate into at the time. This diversity of opinion on the community meant that, when designing activities and support for the community, every stakeholder had a different view on what those should be. Therefore, despite the fact that all stakeholders were supposed to work together to develop and deliver a community-centred approach, this approach was different depending on what priorities every stakeholder thought were important, based on their notion of community. This, to my knowledge, has not been identified in the literature and could explain (within the generalisability constraints of a case study design) the previously observed disconnect between a programme's design to its implementation (De Silva, et al., 2014).

In terms of what was understood as a community asset, this was either people who had social capital (relationships and networks) or cultural capital (ability to speak different languages and relate to people from diverse backgrounds). Although these are important forms of capital that people possess (Caputo, 2009), there are more forms of capital that were not recognised, thus constituting the definition of assets within the FSVP narrow. Community development was also a poorly understood term. Words such as community cohesion, empowerment, integration and development were used by many, without however, providing any context or description of what they mean and how this would happen. These findings show that FSVP lacked a clear understanding of the community it was meant to help and support. This worked towards the construction of a programme unable to produce meaningful change on a community level.

8.1.3. Tackling professional stigma or diluting quality of services?

Although the notions around community contributed to the FSVP's issues, the tensions between professionals and volunteers exacerbated them further. The findings showed profound

resistance from professionals towards working with volunteers which, although well known amongst stakeholders, was never fully addressed. The idea that professionals (particularly in health and social care) have a stigma attached to them was prevalent, without this being corroborated by mothers. Although this was not the case for the FSVP, previous research has shown that volunteers can be preferable care or treatment givers to those who are seriously disadvantaged than professionals (Naylor et al., 2013); a notion with which frontline professionals disagreed. They felt that their relationships with families were excellent; it was the lack of support from their own organisations, they felt, which stopped them from being able to support families more holistically. The use of volunteers was seen by professionals as an attempt to dilute quality of services which could have dangerous results. Volunteers were perceived as threats to professionals, as people who would eventually take their jobs. Professionals felt pushed out of their own professions, underestimated and replaced by people who they felt were not able to work with families. Issues around the accountability of volunteers and the lack of consistency were also prominent, similarly to the work of Brudney & Meijs, (2009). However, it can be argued that these would have been easily resolved, should the resistance had been addressed.

Boundary issues were also a major finding relating to professionals' resistance. There was a prominent fear that volunteers were unaware of where their boundaries ended and professional boundaries began. Similarly to the work of Bochove et al. (2016), lack of credibility of volunteers and the potential reputational and professional damage they could cause were used as explanations as to why professionals never involved volunteers in their work. However, the role and importance of boundaries was clearer for volunteers. They understood the limits of their work and felt that they could never cross professional boundaries due to their lack of knowledge and training. Both these issues of resistance and boundaries led to the profound lack of enablement of volunteers. Whilst many ideas were offered as to how volunteers could

improve professionals' work, this never materialised. There was one case of professional and volunteer collaborative work, but this quickly ended for political reasons originating from the FSVP management. This shows a lack of commitment to help break down the barriers between volunteers and professionals which, strikingly, came from within the volunteer programme. Although the threat to professionalism can partly explain the lack of enablement for volunteers, the last theme offers a more in depth explanation.

8.1.4. Volunteers in early years: missionaries, grassroots workers or selfish people?

The last major theme of the study focussed on the preconceived ideas on volunteers, who they should be and what their role should entail. This was contrasted by volunteers' accounts, their notions about themselves and their role in the FSVP as well as the role and impact of volunteering on them. The ideal volunteer according to professionals appeared to be the missionary; the volunteer who has knowledge about the community, has a number of experiences and is willing to gather and report intelligence about the community back to professionals. Although the term missionary may have negative connotations, in this case it was justified by the belief that professionals want to help the community but cannot because they are unaware of the needs, similarly to the idea put forth by Jackson (2012). A missionary would be able to help professionals improve their service provision and restore their relationships with the community whilst simultaneously helping the community by providing support and advice (South & Sahota, 2010). However, the volunteers that signed up to the programme understood their role quite differently. Given that many of them were seeking asylum in the UK and therefore did not have the right to work, volunteering provided them with the ability to reciprocate the help and support they received whilst gaining experience and knowledge of the UK early years system. Taking into account Putnam's (2000) argument

around social capital and its relationship with wealth, one could argue that because the FSVP volunteers were financially disadvantaged, their sense of reciprocity was higher. Most volunteers understood their role as supportive and reciprocal; not that of a missionary . In fact, volunteers appeared to have gained much from the programme, from improved confidence and self-esteem to qualifications and work experience. Although the benefits for them were discussed at length, they consistently reported altruistic motives for volunteering. This further shows a misalignment surrounding the role of volunteers; whereas many professionals talked about volunteer motivations as being driven by the desire to develop themselves, in reality their motivations were much more closely linked to altruism (Beyerlein & Sikkink, 2008; Wilson, 2012). The common notions around whether volunteering is an altruistic or a selfish act can indeed, and as shown in the findings of this study do, influence individuals' perceptions of volunteers. In this case, professionals assumed that volunteers were driven by selfish motives; perhaps if they had had the opportunity to understand that their motives were varied and complex, they would have been more willing to support them. Management issues and the professional resistance described earlier, meant that professionals never met the actual volunteers of the programme; they never saw their passion for volunteering and the Stockton Town Centre community. Had professionals been given opportunities to meet and work with volunteers, they would have been more likely to enable their involvement.

This presentation of the findings aimed to summarise them and outline their relevance to the case study as well as interpret them in the context in which the case study took place. The next section will interrogate the findings against previous literature and research in order to place the case study in its wider context before drawing conclusions.

8.2. Findings in the wider literature and research context

The political background to volunteering had a strong presence in the findings of this study, particularly the notion that volunteering is as an inexpensive way to reduce service provision (Crowson, 2011). Conversely, the idea that "we are all in this together" was present in the findings although not as a political rhetoric but from the point of view that all early years professionals ultimately want to help children and their families (Spencer, 2017). The financial pressures that the NHS and local authorities faced at this point as a result of austerity measures inevitably shaped the findings as well as the wider intervention itself. Indeed, many understood the FSVP as an unnecessary use of resources that should have been spent on employing professionals. However, and although the political context shaped the way volunteering was understood, other notions were also prevalent.

8.2.1. Why do people volunteer?

The predominant arguments that the literature offers in its attempt to understand volunteering are around the motivations to volunteer; whether volunteering is inherently altruistic or egotistical. The findings of this study can further these arguments. Similarly to theories and models put forth by economists, volunteers in this study stated that volunteering provided them with benefits such as better employability chances, increased confidence and self-esteem and qualifications relating to their interests. One could argue therefore that the investment model (Roy & Ziemek, 2000) where a person's volunteering is a form of investment in their future is particularly relevant. However, and although this may be the case for some volunteers, not all volunteers in this study aimed to gain employment through their volunteering. Some of them held part time jobs and volunteered their free time because they enjoyed early years work and had previously benefitted from children's centres. This is in agreement with psychologist MacNeela's (2008) study which found that personal connections to organisations can lead to

people volunteering for those organisations. Nevertheless, this was not the case for volunteers who were new to the UK at the time of the interviews. For them, their humanitarian concerns and particularly their religious beliefs meant that volunteering was almost an obligation, something they ought to be doing. As Omoto and Snyder (2002) note, personal values are amongst the five motivations to volunteer. In addition, as Stukas, et al. (2016) found, feeling an obligation to help others shows higher altruistic motives and thus people tend to volunteer for longer. Given that all volunteers in this study volunteered throughout the FSVP's three year course, this argument appears plausible.

Another important set of theories that are of particular relevance to the findings of this study is the set of sociological theories around volunteering. Human capital theories posit that a person's education, training, knowledge, skills and family values are all forms of capital and can act as predictors of volunteering (Becker, 2008). Son and Wilson (2017) showed that higher levels of education have consistently predicted volunteering. The majority of volunteers in this study were university-educated professionals in their own countries, despite the fact that they were unable to use their qualifications for paid employment in the UK. Theories of capital as described by Wilson and Musick (1997) delve deeper into the forms of capital relevant to volunteering. They suggest that in order to volunteer, three forms of capital are needed: human capital (education, skills and knowledge), social capital (networks and relationships) and cultural capital (high social standing). This is in contrast to the findings of this study as most volunteers lacked social and cultural capital (as defined in this theory). Many volunteers did not have networks and relationships with the local community and they did not possess high social standing. The theories of capital therefore, fail to encapsulate the motivations to volunteer for the volunteers in this study.

Social exchange theory as developed by Cook and Emerson (1987) can provide a better understanding of volunteering. This suggests that all relationships are based on exchanges; a person will volunteer if they believe they can gain something out of their volunteering. Gee (2011) showed that parents tend to volunteer in their child(ren)'s school as they see it as beneficial for their children. Some volunteers in this study volunteered because their children attended sessions in the children's centre that delivered the FSVP. It can be argued that they volunteered because they felt that their children would benefit from it. Whilst this may appear egotistical, the motives behind the volunteering can be altruistic as the parents devote their time for their children.

The viewpoint that Benenson and Stagg (2016) put forward with regards to volunteers better captures and describes the volunteers and the experiences they acquired in this study. Whereas theories of capital focus on the capital possessed by volunteers, Benenson and Stagg (2016) focus on the capital that volunteers acquire through the activities in which they participate. This is particularly relevant to this study as, similarly to Benenson and Stagg's work, volunteers in the FSVP were from a disadvantaged socio-economic background. Benenson and Stagg (2016) argue that volunteers can develop human capital (skills, knowledge and employability), social capital (new relationships and networks), cultural capital (sharing of cultural knowledge traditions and beliefs) and political capital (civic life participation and political involvement). Social capital in particular is important to volunteers who are new to a community as it can develop their sense of belonging (Benenson and Stagg, 2016). The findings of this study indicate that volunteers in the FSVP were able to develop human, social and cultural capital as they reported positive experiences in terms of support for personal development, development of friendships and better understanding of the UK system. The findings therefore support the notion that volunteering can be particularly beneficial to individuals from a disadvantaged background. Interestingly, Benenson and Stagg (2016) avoid framing volunteering in terms of

altruism or egoism; they focus on the benefits of volunteering for both communities and volunteers.

Generally, the debate between egoism and altruism on a philosophical level is interesting and useful to continue. This study can offer arguments for both sides, as for some volunteers personal development and employability opportunities were important, whereas for others reciprocity and religious beliefs appeared to be more influential for their decision to volunteer. As Clary and Snyder (1999) suggest, it is rather difficult to differentiate between altruism or egoism as drivers for human behaviour as they can be intertwined and one does not preclude the other. The findings of this study support the notion that volunteers wanted to develop themselves through volunteering but had a strong desire to reciprocate, help and support others. This was particularly evident in asylum seekers' accounts, which can be interpreted as an indication that volunteering can indeed benefit marginalised groups more than other groups. Given their strong desire to reciprocate and the practical circumstances of their work status (not having the right to work in the UK), this study suggests that volunteering programmes could target asylum seekers as a population that can benefit greatly from them. More importantly, asylum seekers have a breadth of capital they can offer which presently is not being fully appreciated. Based on the volunteers from this study, asylum seekers tend to be well-educated professionals with rich experiences, vast cultural knowledge and diversity which, if harnessed appropriately, can add to current communities whilst simultaneously supporting them in developing human and political capital.

8.2.2. Community, assets, development and empowerment: the need for nuanced definitions

The literature and research on community-centred approaches in public health offers a plethora of theories and concepts that are relevant to the findings of this study. Firstly, and following

PHE and NHS England's (2015) categorisation of community-centred approaches for health and wellbeing, the FSVP can be classed as an approach which aimed to strengthen the community and utilise volunteer roles. Through the use of assets (volunteers) the programme aspired to raise awareness of health and wellbeing amongst community members and help them take control of their and their children's health (Kretzmann and McKnight, 1993; Foot and Hopkins, 2010; South et al., 2017). Similarly, the programme aimed to facilitate better health and wellbeing in the community through the organisation of events and sessions facilitated by volunteers (PHE and NHS England, 2015; Rippon and Hopkins, 2015; South et al. 2017). However, several issues were present which influenced the way the programme worked in practice.

The difficulties of defining and understanding community were a prominent finding in this study. In the literature, such issues have been reported. Communities have been defined based on their geography, the shared interests amongst their members and their identities (Smith, 2001). Previous literature and research has shown that people can belong to different communities simultaneously. Given the apparent complexity of the term therefore, it is unsurprising that it can be misunderstood or challenging to grasp as part of a community-centred approach. The findings of this study showed that participants' notions of community encompassed all aspects of communities without however, creating a common understanding. However, as Cohen (1985) noted, the term community can denote both similarity and difference, which is why communities have boundaries (physical, administrative or ideas and beliefs). Therefore, even though the communities mentioned by participants are sub-communities of the geographical area of Stockton Town Centre, they will have their own boundaries and differences to other sub-communities. A community-centred approach therefore will have to adopt a more nuanced understanding of the term to encompass all communities and sub-communities in a locality.

On a similar note, and in addition to the issues of defining community, the findings of this study revealed problems with understanding community development, community assets and community empowerment. Although these terms featured in many accounts, they were poorly described. The traditional deficit-based notions around community were present (Hopkins and Rippon, 2015); the Stockton Town Centre community was problematic and needed intervention in order to be able to develop. Some of the intended outcomes of community development were discussed, without, however, a clear vision as to how they would occur. Reducing health and economic inequalities, building community cohesion and addressing poverty and unemployment were some of the ideas around what a volunteer programme could achieve (Rubin, Rubin and Doig, 1992). Arensberg (2017) argued that in order for these outcomes to be achieved, structural change, particularly around distribution of resources, is necessary. However, this was not discussed by any participants in this study; neither the community nor the volunteers were consulted on how resources would be better spent. More importantly, despite claims that the FSVP was a community-centred approach which focussed on utilising local assets to aid community development, this was not evident. Contrary to Kretzmann and McKnight's (1993) and Mathie and Cunningham's (2003) work on community development, the importance of community assets and the need for bottom-up community approaches, the FSVP displayed more similarities with a top-down approach. This was evident in participants' notions around community assets, community empowerment and capacity building. Assets were understood narrowly, that is, assets were either people with strong relationships with the community or people who could speak more than one language. Even though an asset can be any form of cultural, human, natural, financial, political, social and environmental resources or capital (Wilcox and Knapp, 2000; Burkett, 2011), in the case of the FSVP the understanding of an asset was overly simplified. Little thought was given to the collection of assets that exist in the Stockton Town Centre community which inevitably

resulted in the underutilisation of assets. As Emery and Flora (2006) asserted, when all these forms of capital are utilised and mobilised, they can bring about positive change, which could not have happened in this case.

Alongside community development and community assets, the term community empowerment was frequently used. At a collective level, community empowerment is synonymous with participation and civic engagement (PHE and NHS England, 2015). Increased community participation and engagement was never achieved through the FSVP; in fact, this was a consistent problem throughout the programme's duration. One explanation for this is that the community may have been resistant to change and such a programme was undesired. As Mathie and Cunningham (2003) note, one of the criticisms of community-centred approaches is that they are unable to describe how to implement them in environments where the community is resistant. Whether the Stockton Town Centre community was resistant or the FSVP was unsuitable for their needs cannot be determined through this case study. Wide community consultation would allow further understanding of this.

At an individual level, empowerment means having control over one's life, being able to make decisions about health and wellbeing and having the power to influence change (Laverack, 2006). In this respect, it can be argued that the programme achieved part of its aim, particularly with regards to volunteers. Although it would be very difficult to make any inferences about the FSVP's influence on parents of children, volunteer accounts showed increased confidence, self-esteem, awareness of health and wellbeing issues and solutions for those. Volunteers consistently reported feeling both willing and able to influence change in the community. However, as Aigner, Raymond and Smidt (2002) stated, community empowerment should not be interpreted as empowerment of each individual, but rather as a collective process by which individuals within a community work together to regain power and take control over their

community. This was not evident in the case of the FSVP, perhaps due to a misinterpretation of the term community empowerment. The predominant view was that by empowering volunteers individually, they would be able to empower individuals in the community and community empowerment would occur naturally. This, as shown in the literature and in this research, is not the case. Therefore, in addition to a more nuanced definition and understanding of the community, related terms such as assets and empowerment also need to be clearly understood as part of community-centred approaches.

8.2.3. Professional and volunteer relationships in community-centred approaches

The findings of this study overwhelmingly support findings in the literature regarding the tensions between professionals and volunteers. Similarly to Netting, et al.'s (2004) findings, the resistance shown by professionals towards volunteers was strong and was never alleviated throughout the FSVP's course. Brudney (1990) suggested that age and credentials influence acceptance of volunteers from professionals; older volunteers with expertise in specific areas can be perceived as threats to professionals. However, this was not the case in this study. Due to the fact that professionals and volunteers hardly interacted, professionals were unaware of volunteers' age and credentials. In addition, several misconceptions about credentials and professionalism were prevalent in professionals' accounts. It was assumed that volunteers had no professional knowledge and therefore allowing them to work alongside professionals would risk the standard of care provided to families. Professionals talked about "diluting quality of care" in reference to volunteer involvement, suggesting that they considered volunteers without credentials a threat not to their professionalism but to their clients.

An explanation for the resistance shown towards volunteers could be the absence of leverage in managing them. Similarly to Brudney and Meijs's (2009) findings, professionals in this

study discussed how volunteers are difficult to manage because of the lack of formal contract and payment; professionals have a code of conduct to adhere to and they can lose their job should they breach it, whereas volunteers have nothing to lose. Moreover, and in line with previous research, volunteers were perceived to have a lower status compared to professionals (Brudney and Meijs, 2009).

The issue of ill-defined boundaries that was observed in this study has also been observed in the literature. Bochove, Tonkens, Verplanke and Roggeveen (2016) observed that the expectations towards volunteers can often be conflicting, which leads to professionals feeling threatened. In line with their findings, volunteers in this study were expected to be professional and knowledgeable whilst maintaining a "down to earth" attitude in order to counteract the impersonal attitude of professionals. This led to feelings of insecurity and inadequacy of professionals which, in turn, exacerbated the already tense relationships. Better-defined boundaries, therefore, could alleviate some of these issues.

Thinking more broadly, the underlying idea of community-centred approaches can be perceived by professionals as threatening. The desired shift from top-down to bottom-up approaches can lead to professionals feeling devalued (Netting, Nelson, Borders and Huber, 2004). Bottom-up approaches by definition dictate that the power and control is no longer in the hands of professionals but in the hands of people. Therefore, resistance to this notion is to be expected. In this study, professionals expressed disbelief in the effectiveness of community-centred approaches and called for resources to be spent on employing more professionals rather than implementing such an approach. This further indicates that professionals see community-centred approaches as a threat and therefore are less likely to support them.

Although these findings may appear as negative towards professionals, they need to be considered in the wider political context. As mentioned in the previous chapter, during the three

years of the FSVP, a number of changes occurred. Health visiting was transferred to the local authority, children's centres were reviewed and restructured twice and the NHS Foundation Trust that was delivering the 0-19 health programme in Stockton-on-Tees changed, resulting in numerous staff leaving or transferring to a new employer. Whilst these issues did not necessarily affect participants directly, the fact that these changes took place almost continuously from 2015 onwards meant that job insecurity, fear and anger were predominant feelings for many and were evident in their accounts. In addition, from the outset of the FSVP, professionals were made aware of the fact that their senior managers believed in the stigma professionals carry and their inability to form relationships with families. This was provided as the reason for the existence of the volunteer programme; families were disengaged because they did not want to work with professionals; therefore volunteers would take on the role of liaison to help professionals reconnect with the community. Whilst those beliefs may hold true, the fact that professionals were, in effect, blamed and diminished whilst volunteers were praised and supported meant that professionals felt they had to defend their profession, ability and way of working. Perhaps understandably, given this context, many professionals' attitudes towards volunteers were negative similarly to the works of Netting et al. (2014) and Bochove et al. (2016). As part of community-centred approaches an effort is made to avoid placing blame on communities and individuals within them for their behaviours and choices. In the case of the FSVP, this was replaced by placing blame on professionals and pointing out their inadequacies. Given that, by this study's participants' own admission, the work of professionals cannot be replaced by volunteers' work, the FSVP failed to make professionals feel valued and part of the programme. Instead, they were left feeling inadequate, defensive and trying to prove that they are good at what they do. Therefore, blame avoidance in community-centred approaches should include all stakeholders, not only the targeted community.

8.2.4. Evidence for community-centred approaches

Whilst this study did not aim to establish the effectiveness of community-centred approaches, some of the findings can be of relevance. Mothers who participated in this study were positive about volunteers and felt that the FSVP helped them integrate into the local community. They also reported positive outcomes for their children, particularly around their social and language development. This is in line with findings from previous studies (McLeish and Redshaw, 2015; Thomson, Balaam, and Hymers, 2015). With regards to positive outcomes for stakeholders who participate in community-centred approaches, this study identified the majority of positive outcomes in relation to volunteers. For reasons that will be explored in the limitations section of the study, community outcomes could not be identified as a result of the FSVP. Nevertheless, similarly to Morgan and Ziglio (2007) and Mclean and McNeice (2012) better relationships and networks were reported by volunteers and mothers as well as increased confidence and self-esteem. Many participants expressed notions similar to those of Kretzmann and McKnight (1993) namely that community-centred approaches need to be implemented for a number of years before their impact can be evident and measured. However, this thesis argues that the FSVP had fundamental design and implementation issues which would not have necessarily improved over time and therefore the relatively short timescale of the programme did not contribute to its shortcomings. Nevertheless, this thesis does not condemn all community-centred approaches; rather it seeks to gather the learning from the FSVP in order to inform future practice and ensure that similar programmes are designed and delivered in a way that they can have a meaningful contribution to the community they target.

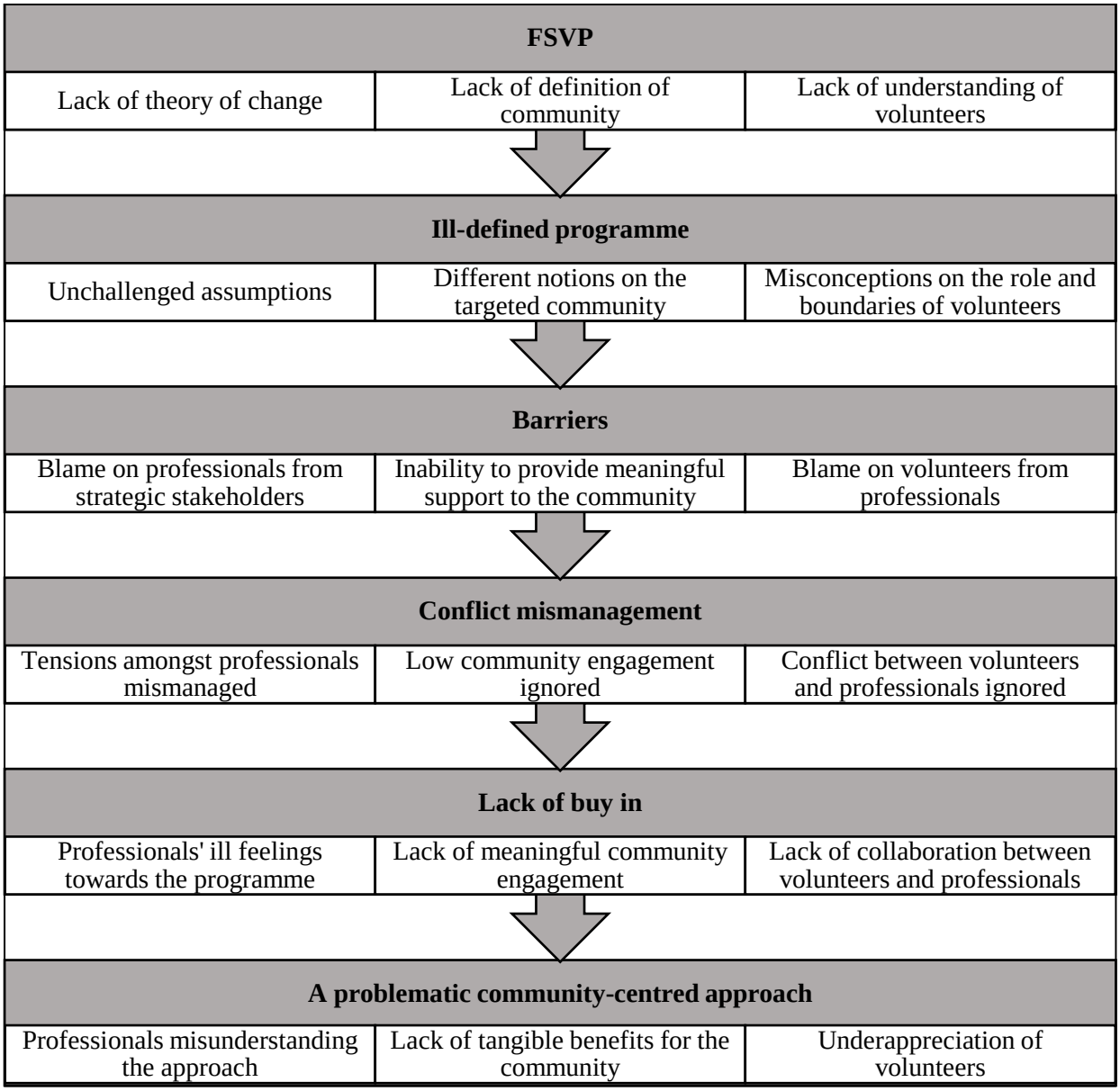
8.3. A strategy model for community-centred approaches

The qualitative data that were collected as part of this study, along with the theoretical and research contributions from different disciplines, helped form a clear picture of what

volunteering is and how it worked in this case study's context. Given the fact that public health is a primarily applied field which uses theory and research evidence to inform practice, it was important that this PhD contributed to the field through the development of a practical model for similar programmes.

A model was developed outlining the causal relationships between deeply rooted issues as identified in this study and the way they influenced its course, as a way of conceptualising the difficulties encountered by the FSVP (figure 8.1).

Figure 8.1.: FSVP practice model



As argued throughout the findings and discussion chapters, the main issues of the FSVP were rooted in the lack of a theory of change, the lack of shared understanding of community and the lack of understanding of the role of volunteers. These led to an ill-defined programme with little consensus on what it meant to achieve, whom it was targeting and how it was meant to work.

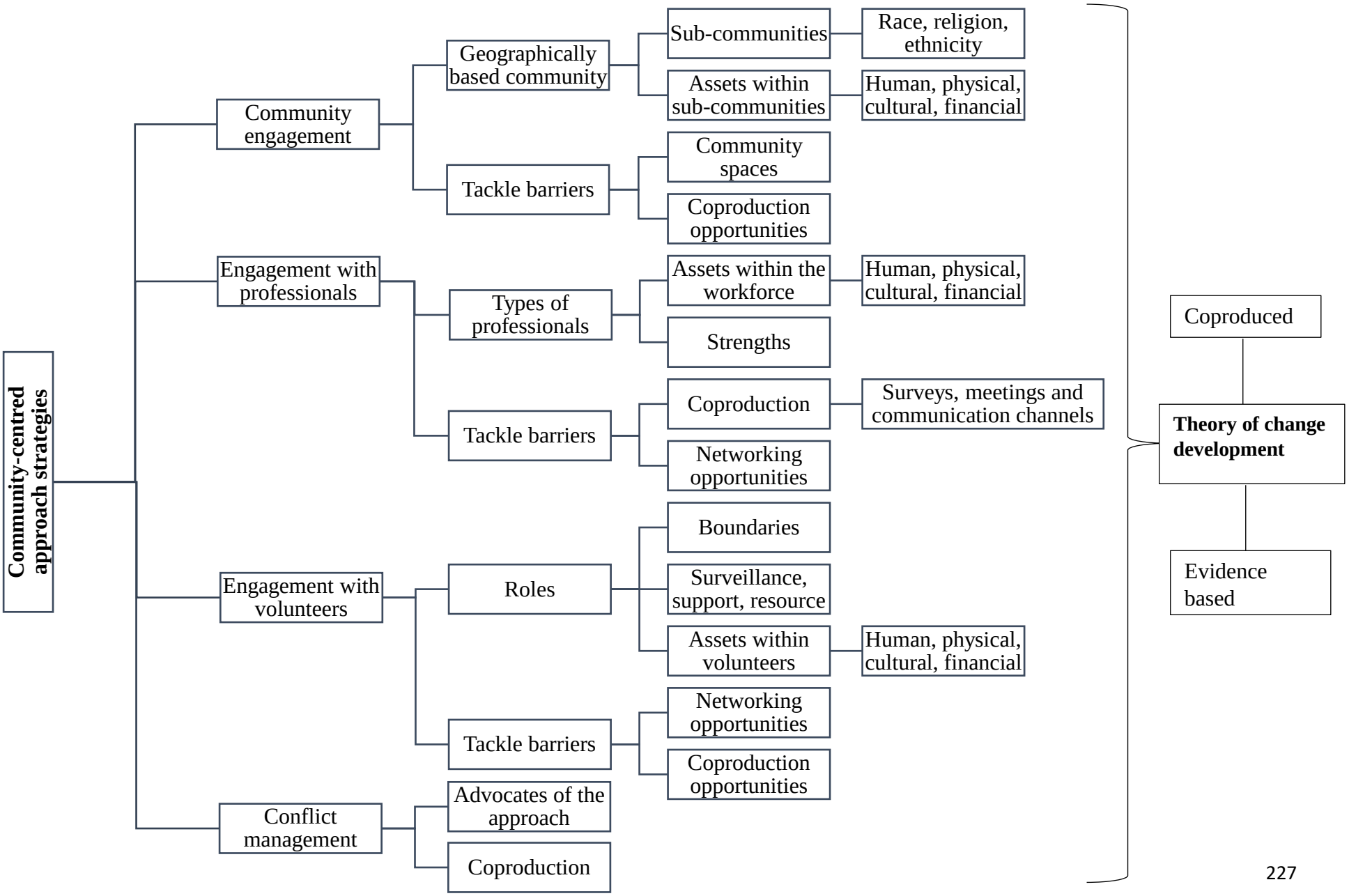
The barriers identified, particularly around blame on professionals from strategic stakeholders, blame on volunteers from professionals and the inability of the FSVP to provide activities

which interested the community, led to a series of conflicts that were mismanaged. The fact that professionals felt devalued by strategic stakeholders was never acknowledged and contributed to the already existing tensions. The low community engagement, and therefore the conflict between the needs/desires of the community and the support provided by the FSVP, was not acted upon which meant that it continued throughout the programme. Moreover, the conflict between professionals and volunteers, although well known amongst stakeholders, was neglected. Therefore, the conflict mismanagement resulted in lack of buy in from professionals and the community. Even though volunteers continued to volunteer in the programme, meaningful collaboration between them and professionals was never facilitated. All these issues inevitably led to a problematic community-centred approach which left professionals with feelings of mistrust, the community without any tangible impact and volunteers underutilised and underappreciated.

This thesis has argued that these shortcomings were a result of the lack of community understanding and engagement, lack of understanding and engagement with professionals, misconceptions about and lack of meaningful engagement with volunteers and conflict mismanagement. With these issues and mind, and given the absence of a theory of change, the FSVP was a problematic community-centred approach. Thinking more broadly than the FSVP and using learning from literature and research, community engagement is the pillar of community-centred approaches (Kretzmann and McKnight, 1993). Without it, such an approach becomes a top-down intervention. Lack of professionals' engagement and its impact on such approaches has not been well documented in the literature. Given the profound influence professionals had on the FSVP, it is argued that engagement from professionals should be a priority in community-centred approaches. Misconceptions held by professionals about volunteers have been reported in the literature (Brudney, 1990). Such misconceptions existed in this case where the role of volunteers was not clearly defined resulting in their

underutilisation. In recognition of the importance of these findings, a strategy model was developed. The model argues that four strategies for engagement and management of stakeholders can facilitate the development of a theory of change and lead to a focussed, well-planned community-centred approach using volunteers. It argues that the strategies are best utilised as preparatory steps before the development of a theory of change of a community-centred programme can begin. Using those strategies before developing the theory of change can facilitate a better understanding of the targeted community, the professionals and volunteers in the programme. By understanding the main stakeholders and putting strategies in place to ensure their engagement, as well as having conflict management strategy, can prevent a number of issues. More importantly, they can ensure that a community-centred approach is true to its name and aim, facilitates co-production work amongst stakeholders and may result in better public health and community outcomes. The strategy model is presented in Figure 8.2. All strategies will be explained in detail in the following sections.

Figure 8.2.: Strategies for community-centred approaches using volunteers


Community-centred approach strategies
Community engagement
Geographically based community
Sub-communities
Race, religion, ethnicity
Assets within sub-communities
Human, physical, cultural, financial
Tackle barriers
Community spaces
Coproduction opportunities
Engagement with professionals
Types of professionals
Assets within the workforce
Human, physical, cultural, financial
Strengths
Tackle barriers
Coproduction
Surveys, meetings and communication channels
Networking opportunities
Engagement with volunteers
Roles
Boundaries
Surveillance, support, resource
Assets within volunteers
Human, physical, cultural, financial
Tackle barriers
Networking opportunities
Coproduction opportunities
Conflict management
Advocates of the approach
Coproduction
Theory of change development
Coproduced
Evidence based

8.3.1. Strategy for engagement with the community

Community engagement can be challenging particularly for communities which have high levels of deprivation (Peterman, 2000). In order for community empowerment and capacity building to take place, the engagement of the community is a prerequisite (Aigner, Raymond and Smidt, 2002; Philips and Pittman, 2014). As this study has shown, for true community engagement to occur, the community needs to be thoroughly understood. This strategy therefore proposes ways to ensure better understanding of the community.

It is acknowledged that community-centred approaches are implemented on a locality basis and therefore a community needs to be initially defined geographically. However, based on Cohen's (1985) work, particularly around the notion that community signifies both similarity and difference, and Smith's (2001) work, which suggests that community members can belong to different communities simultaneously, work can be done to identify all the sub-communities within a locality. Taking Stockton Town Centre and the findings of this study as an example, the locality where the FSVP was implemented in involved the White British community, the Muslim community, the Christian community, the asylum seekers community, the Albanian community and others. Due to the fact that this proposed strategy of identifying all the sub-communities never took place, it is not possible to know exactly how many sub-communities existed and what their assets were. By using this strategy to identify sub-communities, their assets can be better mapped. It has to be acknowledged however, that the identification of sub-communities can be an infinite process. Sub-communities can be divided by ethnicity, which was prevalent in this study, but other sub-communities can include sexual orientation, age, health issues etc. This thesis therefore argues that, a systematic way of identifying sub-communities is essential to provide an enhanced understanding of the community as a whole with the acknowledgement that it will never be complete. It can certainly, however, provide a

shared understanding of who a community approach is targeting and why. Most importantly, when this happens in co-production with the community itself, more and more sub-communities can be identified and included in the approach. Co-production is a vital part of the model proposed and it means that a sharing of power between stakeholders can occur, which is different to consultation (Rippon and South, 2017). Consulting the community on their needs is important but the decision-making needs to include them as active participants rather than the model of the FSVP which meant that decision-making sat with strategic stakeholders.

Similarly to Wilcox and Knapp 's (2000) definitions of assets, these can be financial, political, social, human, physical and cultural. Mapping those, can help identify the physical spaces where different communities come together, the people who are most influential within those communities and the strengths that each community has. Based on those, and using community assets, opportunities to break down barriers for certain communities can be revealed. By identifying physical spaces (assets) where sub-communities come together co-production can happen. For example, churches where the Christian community comes together can be a useful place for co-production work which can identify their strengths, desires and aspirations for their community. By understanding those before developing a theory of change for a community-centred programme, the programme can be focussed on what the community needs rather than the needs being imposed on the community based on epidemiological data (Hopkins and Rippon, 2015). Moreover, certain sub-communities will be more engaged than others; by giving them a meaningful voice in decision-making it can be argued that other, less engaged communities will follow.

Using therefore this strategy for community understanding and engagement, a community-centred approach can be truly community driven as the community and sub-communities will have been involved meaningfully and the programme will have been shaped by their needs and

desires. In addition, barriers similar to the ones identified in this study of misunderstandings around the community such an approach would serve, can be prevented and a bottom up approach can be promoted.

8.3.2. Strategy for engagement with professionals

This strategy is arguably equally important as the strategy for community engagement. The role of professionals within community-centred approaches has been somewhat ignored both from the literature and research. Although the resistance from professionals towards working with volunteers has been documented (Netting et al., 2004) and justified by the fact that professionals see bottom-up approaches as devaluing to their professionalism (McAllum, 2018), professionals have been largely neglected in the literature for community-centred approaches. This study suggests that engaging with professionals and ensuring their support for the approach is crucial for its operation. Given the resistance towards and lack of enablement for volunteers that was evident in the FSVP as well as other programmes previously (McAllum, 2018), it is argued that engagement with professionals should have occurred prior to the programme's implementation.

A strategy therefore for engagement with professionals is being proposed. Identifying the types of professionals that need to be involved in order for a community-centred approach to be implemented is the first step towards engagement. In the case of the FSVP, health visitors, midwives, early years professionals in the local authority and the children's centres were supposed to work together and with volunteers in order to support families (A Fairer Start brief, no date). However, not all these professionals agreed with the approach adopted and different professionals felt they had different responsibilities towards families. Health professionals felt strongly about their duty of care, whereas early years professionals who were used to working

with volunteers felt differently about their involvement with families. These differences of opinion ought to be known from the outset so that they can be addressed and alleviated. Similarly to community assets, there will be assets within the workforce that can be utilised (Mathie and Cunningham, 2003). In the FSVP professionals were seen as deficient which led to them feeling devalued and unsupportive of the programme. Recognising the strengths of professionals and the assets amongst them can make them feel active participants in the approach, with a lot of experience and expertise that can improve the reach and operation of the approach (Hopkins and Rippon, 2015). Similarly to the strategy for community engagement, utilising spaces and times where different types of professionals come together as co-production opportunities can ensure that the community-centred approach is sensitive not only to what the community wants/needs but also accounts for the needs and desires professionals (Krezmann and McKnight, 1993). This can alter attitudes observed in this study of "us" versus "them", help professionals feel valued and ensure their support for the approach. Generally, the theory and literature on community-centred approaches sees professionals as out-of-touch, strict workers who do not understand and cannot respond to the needs of the community. However, as shown in this study, this is not always the case. Whilst this may be truthful in the case of senior managers, frontline professionals are involved in the community and their relationships with families should not be dismissed as less meaningful. Based on the evidence from mothers in this study, professionals were well-respected and appreciated for their work. Some volunteer accounts reiterated these notions with volunteers emphasising how crucial the help and support from health visitors in particular was. Instead, therefore, of professionals being thought of as less important in community-centred approaches, this thesis argues that their involvement is pivotal to the success of such an approach. Involving them in co-production efforts early in the design of the approach can strengthen the approach.

8.3.3. Strategy for engagement with volunteers

The next strategy involves engagement with volunteers. Although it is often assumed that people will volunteer in community-centred approaches for a multitude of reasons which have already been explored previously, there is a need to ensure that their volunteering will be meaningful both for them and the community. Designing a volunteer programme which can help volunteers develop different forms of capital is vital as it can empower them, improve their self-confidence and esteem (Hustinx et al., 2010). Perhaps more importantly, a volunteer programme which ensures that the capital already possessed by volunteers is appropriately harnessed can ensure a community-centred approach which utilises assets to their full potential and can produce community change (Benenson and Stagg, 2016).

However, as shown in this study and in the literature, establishing clear roles for volunteers is essential (Brudney & Meijs, 2009). Contrary to the case of the FSVP, stakeholders within a volunteer programme need to have a good understanding of the role and purpose of volunteers. If their role is surveillance of the community with the purpose of identifying gaps in service provision, their boundaries, remit and scope will have to be adapted accordingly. If their role is to support professionals then the training requirements, boundaries and scope will be different. Thus, a clear understanding of the role of volunteers is essential. Boundaries are also crucial; they can prevent or alleviate tensions with professionals, provide focus for volunteers and ensure meaningful joint working (Bochove, Tonkens, Verplanke and Roggeveen, 2016). Similarly to the previous strategies, volunteers will have assets amongst them that can be harnessed (Emery & Flora, 2006). The forms of cultural, human and social capital amongst asylum seekers in this case were underappreciated but in a volunteer programme which recognises them, there is the potential to help both volunteers and the community.

Co-production and networking opportunities for volunteers are also crucial. Giving professionals, volunteers and the wider community an opportunity to come together and interact can prevent tensions, give professionals the reassurance they need in order to enable volunteers' work and give volunteers the opportunity to meet and discuss with professionals the best ways for working together. Given that this never happened in the case of the FSVP, it is argued that this strategy could benefit a community-centred volunteer programme. In addition, the findings of this study showed several misconceptions around volunteers and their motivations. Opportunities for professionals to understand volunteer motivations would alleviate potential tensions and facilitate collaboration.

8.3.4. Strategy for conflict management

Any practice model needs to be realistic and take into account the wider political and economical context within which it is implemented. As mentioned in previous chapters, the current economic context largely influenced the findings of this study particularly around the feelings of professionals towards community-centred approaches and volunteering. With this in mind, such a programme needs to take into account that conflict may be unavoidable particularly for professionals who feel that their job may be under threat from volunteers (Brudney, 1990). Therefore, the fourth and last strategy in the strategy model is around managing conflict.

One of the ways to manage conflict is to have community-centred approach advocates; people who understand and value the approach and advocate for it within different settings and organisations. Advocates can act as catalysts for change and ought to be representatives of all stakeholders; advocates from the community, the workforce, the volunteer force, the strategic stakeholders and the middle management, all have a role to play in ensuring that the approach is understood and accepted. Advocates can act as points of contact for people who are uncertain

of the approach or the way it works, they can identify challenges and feed those back to stakeholders so that they can be tackled before the development of a theory of change begins. Lastly, advocates ensure that co-production work happens. Facilitating co-production in the early stages and continuing it throughout the development stages of the programme, can ensure that all stakeholders feel valued and their opinions respected (Mathie & Cunningham, 2003). Naturally, certain compromises will have to be made from all stakeholders but co-production can ensure that those are discussed and agreed.

Ultimately, what this strategy model posits is that understanding and respect for all stakeholders within a community-centred approach is key to creating a programme that works best for everyone. It is argued that when all stakeholders feel valued and have their opinions heard, they are likely to engage with the approach, take ownership of it and support it. By using these strategies to facilitate stakeholders' engagement and co-production work, the development of a theory of change can begin.

8.3.5. Development of a theory of change

The development of a theory of change therefore is seen as an outcome of this preparatory engagement work. Having used these strategies the theory of change can be revealed as the needs and desires of the community, professionals and volunteers are known as are their strengths. Basing the theory on these strengths and recognising where the boundaries of work are, can help produce a meaningful and realistic theory of change. At this point, stakeholders overseeing the approach can combine the learning from the preparatory work with the evidence of what works in community-centred approaches and produce a theory that is both coproduced and evidence based.

This model therefore combines the learning from the literature on community-centred approaches and volunteering with the findings of this study and proposes these four main strategies that if used, can lead to the production of a holistic, community-centred theory of change that accounts for many of the potential issues in its implementation. Positioning community-centred approaches in the context of complex interventions helps emphasise the need for the preparatory work proposed in order to produce a functional bottom-up programme which has the potential to produce meaningful and tangible change in the community (May, Johnson, and Finch, 2016). Although many models for community-centred approaches exist in the literature, many of which have been presented throughout the thesis, to my knowledge, this is the first model to include the important role of professionals and conflict management in such approaches.

8.4. Reflections on the research process

Before presenting the strengths and limitations of the study, it is useful to provide a reflection on the research process itself as it is relevant to both the study as well as myself as a researcher. As explained in Chapter 5, this study was commissioned by an external to the University organisation as an evaluation. This meant that I had to work and collaborate with the commissioners in order to conduct the evaluation and the PhD. Working alongside commissioners and relying on them for certain aspects of the study (i.e. participant recruitment) was challenging for a number of reasons, some of which have been outlined in previous chapters (Chapter 5, sections 5.6.2. and 5.6.5) and others will be explored further here.

Firstly, the organisation that oversaw AFS, the FSVP and this study was a third sector organisation with very little experience of commissioning research and evaluation. This meant that the people overseeing the research had to learn the research and evaluation processes whilst simultaneously having to design and implement a £250,000 initiative with two major aspects

(systems change and the FSVP). This, by itself is a big task which was compounded by the lack of leadership for AFS; the responsibility for the design and delivery of AFS as well as the oversight of its evaluation fell onto a project assistant who was working on two other projects throughout the implementation of AFS. The steering group that had the ultimate responsibility for AFS met monthly, but its purpose was to monitor its progress and remove blockages; not to oversee the day-to-day activities of AFS. As a result, the steering group needed specific information on issues or barriers and had little understanding of what was happening on the ground.

Partly for this reason and partly because AFS was an initiative that could have presented an opportunity for an action research project with elements of co-production (i.e. getting commissioners involved in the research design, conduct, interpretation and dissemination of the research), the commissioners of the evaluation had originally requested a close working relationship with me. The idea was that, by having a close professional relationship, I could alert them to any issues or barriers in the implementation of AFS as they arise, as opposed to me conducting an evaluation that they knew nothing about until its completion. Given their initial investment in the project, it was understandable that they wanted to be informed of potential issues as soon as possible so that they could rectify them and make the project a success. Therefore, they had requested interim reports, aligned with the data collection phases. I would write those interim reports and present them to the steering group. The steering group could then feed their thoughts about the research and its findings back to me and I could incorporate those into the research. I felt that this was a good plan as I could have shown how a project that is conducted iteratively (design-implementation-evaluation-adaptation) and, in some respects, in co-production, can potentially achieve better outcomes than a programme implemented and evaluated in isolation.

However, the research process was different. After the scoping interviews and focus groups, I wrote the first interim report for the commissioners which outlined some of the emerging issues I identified. The main issues identified were the lack of leadership for AFS and the lack of buy-in and belief in the project by the participants I interviewed. Unfortunately, the scoping interviews and focus groups were largely negative thus rendering my report negative. This was hardly unexpected at that stage (and this was clear in the report itself) as the scoping interviews took place prior to the implementation of the programme and therefore there were no success stories or tangible outcomes that participants could have reported. This report, perhaps understandably, was not well received by commissioners who were dissatisfied with the findings and the issues reported. This was probably a reflection on the working relationship (or lack thereof) with the commissioners, in which mutual expectations were not clarified and sufficient trust was not built. This points to the heart of co-production and, in this case, a breaking down of the co-production process. This resulted in me being uninvited from groups I was originally part of and the commissioners requesting the evaluation to be conducted in isolation and without informing them of any emerging issues. Therefore, this interim report was the only report I wrote before the final evaluation report.

Upon reflection, I realised that perhaps as a researcher, I could have done more to alleviate some of these issues, cultivate a good working relationship and build trust with the commissioners. I made the incorrect assumption that any organisation that commissions a research or an evaluation knows and understands research. This is not true and this is one of the biggest lessons I learned doing this PhD. I could have spent more time in the beginning of the study explaining the research processes and potential outcomes to my commissioners. Had I done that, they would have known that I am bound by certain ethical rules and that participant confidentiality and anonymity are of the utmost importance (see also section 5.6.2.). They would also have known that it is both expected and unsurprising for a new programme to have

issues, particularly around buy in, in its infancy. Had I explained that, they would have expected a somewhat negative report following the scoping interviews. However, in true co-production work this is a two-way process. In the same way that I could have been clearer about the research process, the commissioners could have explained their own decision making and commissioning pressures and priorities and, perhaps more importantly, they could have worked with me to build trusting relationships together in order to manage difficult messages. In as much as my inexperience in such projects meant that I missed opportunities to develop working relationships, the commissioners did not help me understand their priorities and needs from the outset; it was something that I learned in the process of doing this PhD.

Another point to reflect upon with regards to my work is around report writing. All previous reports I had written up to that point were for local authorities whereas this report was for a third sector organisation. This is relevant because local authorities, perhaps because they routinely commission evaluations, are relatively aware of the potential findings; particularly findings which relate to lack of resources. When I wrote the interim report for my commissioners, I presented the issue around the lack of leadership for AFS (because it was identified as an issue by participants). This was a problematic finding for the commissioners because they felt that they had assigned enough resource to the oversight of AFS. I could have been more sensitive in presenting this issue since a third sector organisation relies on obtaining funding from external sources, funding which in recent years has become scarcer. Therefore, the resource they had dedicated to AFS may have been their only available resource. Generally, as a researcher, I could have been more sensitive and aware of the challenges that my commissioners faced as well as the pressures that they were under with this particular programme. Although everything that was included in the interim report (and the final evaluation report) was based on the views of the participants, I could have communicated it in a different way.

The purpose of this reflection was to help the reader understand some of the practicalities of conducting research and evaluation alongside commissioners and how circumstances can, and do change throughout the process. More importantly, this reflection helped me understand the learning points from this PhD above and beyond the subject itself. Doing research in an ever-changing context (politically and economically) means that all stakeholders involved are under different pressures, have different agendas and different capacities. Negotiating these pressures is challenging and not always successful. I believe that despite the challenges that I have outlined throughout this thesis, I conducted a piece of work that was robust and true to the voice of participants. I believe that the learning from this work is valuable to myself, the commissioners and everyone else who was involved in it.

8.5. Strengths and limitations of the study

This PhD study had some limitations that need to be noted. The first limitation is methodological. Case study methodology is a well established methodology in qualitative research but it has its shortcomings (Creswell, 2013). It provides in depth insight into a specific bounded system and therefore the applicability of the findings to other contexts or settings can be questionable (Houghton et al., 2015). However, the fact that the findings of this study are in line with previous findings on similar community-centred approaches indicates that they add value to the evidence base. Moreover, due to the variation in community-centred approaches, the way they are designed and implemented in different settings and the fact that there is not, currently, a single model or methodology to use when designing such an approach, every community-centred approach presents a unique case study that ought to be studied. As South, et al. (2017) note, a unified evidence base for such approaches is not possible given the current reporting variability. Thus, studying each approach in depth through the use of the case study methodology provides an opportunity to delve into the intricacies of such approaches in a way

that other methodologies would not allow. For example, had the FSVP been studied through a positivist approach, it would have been deemed unsuccessful without, however, understanding the reasons why. Professionals' resistance to volunteers and the lack of understanding of the community would not have been captured adequately. Other qualitative approaches which focus on the lived experiences of individuals may have missed the importance of a theory of change. The case study methodology allowed the researcher to explore in depth all the issues pertaining to the FSVP and place them in the context in which they occurred.

Another important limitation of the study was the changing context in which it was undertaken. As described in Chapter Five, this study's initial design was largely different to the one reported here. This happened as a result of changes that were beyond my control as a researcher. Given that I was an external and independent researcher, I had no control over implementation issues, delays and moving goalposts set by stakeholders. Although this added to the credibility of the study as I remained an objective set of eyes throughout the programme, it meant that my research was sensitive to the changes of the context (Shenton, 2004). For this reason, I decided to adopt a research design that viewed these changes as important to be captured and ultimately led to a study which explored in depth the intricacies of the FSVP, community-centred approaches and volunteering within them.

Another limitation of the study, and indeed of qualitative research is that of generalisability (Berg & Lune, 2014; Bryman, 2016; Walliman, 2005). Despite the in depth analyses and the multiple information sources from which data is collected, assertions about generalisability of the findings cannot be made. Nevertheless, the aim of qualitative research is not to generalise; it is rather to understand the perspectives of individuals on a certain phenomenon. This is in keeping with the researcher's epistemological stance which accepts that generalisability of findings is not the ultimate goal of her research; rather it is to understand the phenomenon in

the context of the case study in question. Moreover, by comparing the findings of a case study to the findings of previous studies both quantitative and qualitative can provide the researcher with the ability to make assumptions of how the findings could be transferred to different settings (Creswell, 2013).

Moreover, a limitation of this study was conducting it in the context outlined in sections of this thesis (5.6.2. and 8.4). Working alongside commissioners who are under pressure to deliver a successful programme meant that at times, the goalposts and scope of the study changed, there were ethical challenges that needed to be addressed and there were challenges in maintaining professional relationships. Although this piece of work could have been a great opportunity for a co-produced research, this was not seen as valuable by commissioners. Even though this work was originally designed to be conducted in co-production with commissioners, this was changed in the first year of the study. Similar studies in the future could use some of the learning from this thesis, particularly the reflection notes in the previous section, and conduct a study in co-production with commissioners and other stakeholders.

Lastly, one of the weaknesses of this study was the small sample of community members and more specifically, parents. Whilst the sample of strategic stakeholders, frontline professionals and volunteers was inclusive of the majority of stakeholders who participated in the FSVP, only four mothers were recruited to the study. This happened for two reasons. Firstly, as mentioned earlier in the thesis, community involvement was low for the programme as a whole and therefore there was a small number of parents from which the researcher could recruit. Secondly, most of the mothers who engaged with the programme were new to the country at the time of the interviews. This meant that many of them could not communicate comfortably in English. Although it would have been possible to conduct the interviews with volunteer interpreters, this may have compromised the quality of data and was impossible in the financial

constraints of the study. Therefore, the conclusions that this study can draw around the impact of the FSVP on the community and more importantly parents, are limited. Although these limitations need to be noted when reading this thesis, they should not undermine the importance of the findings of this study. There are novel and significant conclusions that can be drawn from the findings and meaningful implications for theory, research and practice. These are outlined in the next and final chapter of the thesis.

9. Chapter Nine: Conclusion and implications

This chapter draws the thesis to a close by highlighting the conclusions of this study and describing its implications for theory, research and practice.

9.1. Conclusion

This PhD achieved its aim, answered the research questions it set out to explore and provided an insight into what volunteering is and how it works in community-centred approaches in public health. Volunteering was understood differently by stakeholders depending on their status. Strategic stakeholders saw it as a community engagement approach that could help them gather intelligence and adjust their services to meet community's needs. Frontline professionals felt threatened by volunteering, as they understood it as a way to replace them. Volunteers saw it as a way to show gratitude and reciprocate the help they previously received from the community. Mothers felt that volunteers were hard workers who, although could not replace professionals, helped them and their children integrate into the local community.

Volunteering in the context of the case study did not work as it was meant to, as it was influenced by a number of elements. Lack of a shared understanding as to what community the programme aimed to support as well as absence of a clear vision meant that despite good intentions, every stakeholder held a different view on what they were trying to achieve and how. Stigmatisation and blame of professionals as well as socio-political circumstances meant that professionals resisted working with volunteers and accepting them as part of the programme. This meant that the holistic support that was originally envisaged for communities was not offered. Lastly, the misconceptions around who volunteers should be and who they were meant that the volunteers who were part of the programme were not utilised to their full potential. Although they were supported in developing themselves and despite the fact that they

showed great sense and willingness to help others, the received little opportunities to do so. However, the support and development of volunteers was one of the positive aspects of the programme.

In response to these findings, and following their interrogation against previous literature and research, a strategy practice model was developed to guide future volunteer programmes that follow a similar approach to the FSVP. The model proposes four strategies for engagement with the community, professionals and volunteers as well as conflict management as part of a community-centred volunteer programme. The model suggests that these strategies are crucial preparatory work which ought to be conducted prior to the development of an evidence based and coproduced theory of change.

9.2. Implications for theory

With regards to theoretical implications, this study has contributed to theoretical and philosophical debates around the nature of volunteering. The debates that can be observed across disciplines on whether volunteering is altruistic or egotistical (Becker, 1976; Hustinx et al., 2010) have been addressed and the findings of this study positioned within them. The thesis has argued that this debate, although largely academic, influences individuals' perceptions of volunteers and may influence whether they are accepted or rejected by the workforce. Therefore, it is an important debate to continue. However, this study moves beyond this and argues that theory should expand its focus. Rather than attempting to establish what drives volunteer behaviour, theory could explore the organisational processes involved in volunteer programmes, what mechanisms are involved in the acceptance or rejection of volunteers by professionals and how meaningful community engagement can happen. Moreover, theory could explore how a real shift from top-down to bottom-up approaches can be facilitated. The findings of this study support that although both community development and empowerment

are important aspects of community-centred approaches to public health, the ways in which they can be facilitated particularly in severely disadvantaged communities are unclear. Both concepts presently appear utopian given that wealth, resources and power stay with the state/local authority and the idea that these will be relinquished to disadvantaged individuals in order to shape their community is, based on this study, improbable.

9.3. Implications for research

This study has important implications for further research. The effectiveness of community-centred approaches is still contested (McLean, 2012) and although the findings of this study can be interpreted as negative, some of the positive outcomes on volunteers and mothers should not be overlooked or underestimated. Community-centred approaches can be particularly effective for people from disadvantaged backgrounds (Meier, Olson, Benton, Eghtedary and Song, 2007; Robinson, Vande Vusse and Foster, 2016) and this ought to be studied further and in different contexts. Professionals' resistance to volunteers is a subject that is relatively understudied in community-centred approaches with most evidence currently confirming that resistance is an issue without identifying opportunities to rectify it. Therefore, more research is needed to explore the reasons and identify ways to alleviate the tensions between professionals and volunteers. This study makes some suggestions as to how these tensions can be relieved but further research can assess whether the proposed conflict management strategy is useful in tackling these issues. Future evaluations of community-centred approaches could also use the proposed strategy model as an evaluative framework which encompasses all the elements that an evaluation ought to explore. Although not explored in depth in this study, some anecdotal evidence was provided around the lack of support from middle managers to professionals in order to facilitate community-centred work. Future studies could look at how

middle management can influence professionals in the way they work within a community-centred approach.

9.4. Implications for practice

This study aimed primarily to inform practice and through its findings it is hoped that it achieved its aim. The proposed strategy model provides a useful tool for commissioners, programme developers, professionals, volunteers and communities to ensure that they account for most of the potential issues in community-centred approaches. In addition, it provides a guide for researchers and evaluators around the aspects of such an approach that require thinking and planning. Public health practitioners and community workers can use this model to design and implement a community-centred approach to public health and determine its usefulness.

Aside from the model, this study has further practice implications that ought to be mentioned. Given the profound resistance from professionals and misconceptions around volunteers, it is argued that training professionals on what purpose the volunteers can serve and how to meaningfully work with them would be helpful. Similarly, supporting volunteers in understanding some of the professional and financial constraints professionals face could allow them to think their roles and boundaries.

The importance of leadership and ownership was also identified in the findings of this study. A community-centred approach needs to have a leader (or leaders) who are able to identify and rectify problems and blockages, can take ownership of the approach and can ensure that co-production work is facilitated. This does not necessarily mean a strategic stakeholder; the leader can be a member or a group of members of the community or even a board consisting

of representatives from all stakeholders. Certainly, such an approach needs leadership to drive it forward.

9.5. Originality

This study offers original contributions to knowledge around volunteering within community-centred approaches. The issues that were identified in this study particularly around forming a shared understanding of the community amongst different stakeholders have not been reported before. This is vital as it is the fundamental prerequisite of community-centred approaches and ambiguities in what community means and whom it includes can be detrimental to such an approach.

In addition, this study adds to the volunteering literature by emphasising the opportunities volunteering presents for disadvantaged community members and particularly asylum seekers. Their strong reciprocal feelings and their willingness to volunteer as well as the plethora of human, social, cultural and political capital they can offer presents opportunities to widen the volunteer workforce. This would support communities given the breadth of knowledge, skills and abilities as well as asylum seekers as they are eager to lean and integrate into the UK. Although the case around the benefits of volunteering for disadvantaged groups has been made previously, studies on the particular benefits for asylum seekers in the UK are now starting to be conducted. This study therefore, offers a starting point for such studies.

Lastly, this study further adds to the evidence base around the tensions between professionals and volunteers. The detrimental effect such tensions can have on a community-centred approach were shown in the findings. Given that this is a relatively understudied area within community-centred approaches, this study provides additional evidence that could be used to inform future studies.

Most importantly, this PhD adds to public health practice by developing a strategy practice model which can be used as a tool to design community-centred approaches. This model, informed by literature, research and the findings of this study proposes strategies that ought to be used as part of a community-centred approach. Utilising those strategies which aim to provide such approaches with focus, it is believed that the model can be valuable for commissioners, practitioners, professionals, volunteers and the wider community.

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10.Appendices:

Appendix A. Invitation letter professionals and volunteers

Dear INSERT NAME,

Evaluation of 'A Fairer Start'

Researchers at Teesside University would like to invite you to take part in a research study that aims to understand how 'A Fairer Start' is being put into practice. This work is funded by Stockton Borough Council Public Health and Hartlepool & Stockton-On-Tees Clinical Commissioning Group. The project has received ethical approval from the School of Health & Social Care Ethics Committee at Teesside University.

It is felt that 'A Fairer Start' is a useful example of an early intervention programme that is designed to improve development for children 0-3 years old and I would therefore like to invite you to participate. I have enclosed an information sheet with this letter. Please take the time to read this carefully as it provides further details about the project, its aims and the methods to be used. This information should give enough detail so that you are able to make an informed decision as to whether you are happy to take part.

Please note that this letter of invitation has been sent to your on the researcher's behalf by NAME OF ORGANISATION (i.e. Children's Centre, Catalyst). Neither your personal details including your contact details, nor any other information about you, have been released to, or accessed by, the researcher. No member of the research team has been made aware of which members of staff have and have not been contacted in relation to this research study.

If, once you've read the enclosed information, you are happy to take part in this study, please contact Dora Machaira, the lead researcher by telephone/text (01642) 384996, [mobile number to be confirmed] or email t.machaira@tees.ac.uk.

Yours sincerely

Professor Janet Shucksmith

Professor in Public Health

Teesside University

Appendix B. Participant Information Sheet professionals and volunteers

Evaluation of 'A Fairer Start'

This information sheet has been designed to provide you with enough information to help you make an informed decision as to whether you wish to take part in the above study. It will explain what the project is about, what it aims to find out and what you can expect if you take part.

Please note that this study information sheet has been sent to you on the researcher's behalf by NAME OF ORGANISATION (i.e. Children's Centre, Catalyst). Neither your personal details including your contact details, nor any other information about you, have been released to, or accessed by, the researcher. No member of the research team has been made aware of which members of staff have and have not been contacted in relation to this research study.

What is the purpose of this study?

The overall aim of the evaluation is to explore the ways in which 'A Fairer Start' is put into practice, and to look at what are the barriers and facilitators within the project. We want to find out which parts of the intervention work best for which sub groups.

Why would we like to speak to you?

In order to understand how 'A Fairer Start' is implemented, we would like to speak to the people who are most directly involved in its implementation and delivery. As a person who is directly involved in 'A Fairer Start', we feel that your experiences and views will be very useful to us.

How will information be collected?

The information that we will be looking to find out will typically fall into three main areas:

- Information relating to the project itself
- Information relating to the implementation and delivery process
- Information relating to opinions about what makes a successful intervention

In order to understand how 'A Fairer Start' works in practice, we will be speaking to some of the people who are most closely involved with it.

What will I be asked to do?

We are asking you to participate in a single interview with the lead researcher (Dora Machaira). This interview will be designed to find out about your opinions of the 'A Fairer Start' project. It is expected that this interview will last approximately 30-45 minutes and will be held in a private place at a time that suits you.

How will the information be used?

This interview forms part of a PhD study and so it is expected that findings will be used in the PhD thesis that will be produced. It is also expected that the information collected from this study will be used to produce a report for Stockton Borough Council Public Health and Hartlepool & Stockton-On-Tees Clinical Commissioning Group in order to inform the effective delivery of 'A Fairer Start' in the future.

Information obtained during the interview will be transcribed (written up) and analysed to identify a number of common themes and we may use some of your quotations within the report to illustrate a point within a theme. In addition to research reports, it is anticipated that

the findings from this study will be written up for peer-reviewed journal publication and presented at appropriate conferences.

Do I have to take part?

NO. Your participation is entirely voluntary. You are free to choose whether or not you wish to take part. If you decide that you would like to participate then you are also free to withdraw your consent at any time, without question. During the interview discussion you can refuse to answer any question and the researcher will stop at any point if you do not wish to continue. After the interview you will be able to withdraw any or all of your comments for a period of up to one week - after that time the interview will have been transcribed and anonymised.

Will my comments be confidential?

YES. The researcher will not inform anybody of your decision to participate. No personal details (including your name or your job role) will be disclosed in any report that is written. However, given the small number of people being interviewed it is possible that you will be identified by something you say so it is not possible to guarantee anonymity. Nevertheless, the researcher will combat this as much as possible during the reporting phases. In addition, we kindly ask that you do not name any specific people nor give any information that could render anyone or any site identifiable. If you do, that data will be destroyed and not included in the analysis. The recordings of interviews and all paper documents relating to them will be held securely at Teesside University in accord with the Data Protection Act (1998). Only staff directly involved in this evaluation will hear and see these. All data will be anonymised and held for up to 6 years and may be used for future study but only in research projects that have received ethical approval from an appropriate committee.

Are there any risks involved in taking part?

NO risk or discomfort is anticipated to those taking part in this study. Participation will remain voluntary and without coercion. No questions of a sensitive nature are envisaged at any point and at no time will judgement be made about your personal or professional performance.

What happens next?

If you are happy to participate in this research study then please contact Dora Machaira, the lead researcher via telephone/text (01642) 384996, [mobile number to be confirmed], or e-mail t.machaira@tees.ac.uk. An interview will be arranged once you have expressed an interest with the researcher.

I would like to take this opportunity to thank you for taking the time to read this information sheet. If you wish to speak with someone who knows about the study but not directly involved in it, or if you have any complaints or comments you may contact:

Alasdair MacSween Ph.D B.Sc.(Hons) MCSP

Chair of School of Health & Social Care Research Governance and Ethics Committee

P1.18 Parkside West Offices

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Middlesbrough, TS1 3BA

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Appendix C. Consent form professionals and volunteers

Evaluation of 'A Fairer Start'

Researcher: Dora Machaira

Please read the following statements and indicate your agreement by signing your initials in the appropriate boxes to grant permission for the study to take place.

I confirm that:

I have read and understood the information sheet dated [insert date] and have had the opportunity to ask questions. ☐

I understand that taking part in this interview is voluntary. ☐

I understand that I can leave the discussion at any time without having to give a reason. ☐

I understand that the discussion will be recorded and then written down. ☐

I understand that any information I give today will be kept confidential and that no personal information that may identify me will be used in the final written reports. ☐

I understand that the recording of my interview and all paper documents relating to it will be held securely at Teesside University in accord with the Data Protection Act (1998). Only those directly involved in this evaluation will hear and see these. All data will be anonymised and held for up to 6 years and may be used for future study (secondary analysis) but only in research projects that have received ethical approval from an appropriate committee.

☐

I agree to take part in the interview. ☐

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Name Date Signature

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Name of Researcher Date Signature

Appendix D. Invitation letter parents

Dear INSERT NAME,

Evaluation of 'A Fairer Start'

Researchers at Teesside University would like to invite you to take part in a study that wants to understand how 'A Fairer Start' works. This is supported by Stockton Borough Council Public Health and Hartlepool & Stockton-On-Tees Clinical Commissioning Group. The project has received ethical approval from the School of Health & Social Care Ethics Committee at Teesside University.

We think that 'A Fairer Start' is a good example of a project that tries to improve development for children 0-3 years old and for this reason I would like to ask you to participate. With this letter you have also got a leaflet with more information. Please take the time to read this carefully as it gives more details about the study, its aims and the methods to be used. This information should give you enough detail to decide if you want to take part.

Please remember that this letter has been sent to your on the researcher's behalf by NAME OF ORGANISATION (i.e. Children's Centre, Catalyst). The researcher does not have your personal details and does not know who has been invited to take part and who has not.

If, after reading the leaflet, you are happy to take part in this study, can I ask that you contact Dora Machaira, the lead researcher by telephone/text on (01642) 384996, [mobile number to be confirmed] or email t.machaira@tees.ac.uk.

Yours sincerely,

Professor Janet Shucksmith

Professor in Public Health

Teesside University

Appendix E. Participant Information Sheet parents

Evaluation of 'A Fairer Start'

This leaflet has been designed to give you enough information to decide if you want to take part in the study. It will explain what the project is about, what it aims to find out and what you can expect if you take part.

What is the purpose of this study?

The overall aim of the evaluation is to find out what works well and what doesn't in 'A Fairer Start'. We want to find out what you liked about it, what you didn't and how we can improve it.

Why would we like to speak to you?

In order to understand how 'A Fairer Start' works, we want to speak to parents who have some experience of it. As a parent who is taking part in 'A Fairer Start', we feel that your experiences and opinions will be important

How will information be collected?

The information that we want to find out will fall into three main areas:

- Information about 'A Fairer Start'
- Information about activities you and your child have participated in
- Information about your opinions about how we can improve 'A Fairer Start'

What will I be asked to do?

We are asking you to take part in a discussion with the researcher. During this discussion we will ask questions about your views and experiences of 'A Fairer Start'. This discussion will take place in the children's centre and will last for around 30-45 minutes. We will record these discussion and write them up later.

How will the information be used?

This discussion is being done as part of a university degree and so the information will be used in the final report that will be written. Also, the information collected from this study will be used to write a report for Stockton Borough Council Public Health and Hartlepool & Stockton-On-Tees Clinical Commissioning Group in order to improve 'A Fairer Start' in the future.

The information you will give us will be written up and analysed to find a number of common themes and we may use some of your words within the report to make a point within a theme. The results from this study will also be written up other publications and presented to the public.

Do I have to take part?

NO. It is up to you if you want to take part. If you decide that you would like to take part then you can stillrefuse to take part at any time, without question. During the discussion you can refuse to answer any question. You can leave the room at any point and you do not have to explain yourself. However, we cannot delete what you have said up until that point.

Will my comments be confidential?

YES. The researcher will not tell anybody if you are taking part or not. No personal information (including your or your child's name) will be in any report that is written. However, because

not many parents are taking part, some people may be able to recognise you by something you say. However, the researcher will try to avoid this as much as possible. We are also asking you not to name any specific person or place (for example, specific volunteers or specific children's centres) during the discussion. If you do, that information will not be used for the research. The recordings of discussions and all paper documents relating to them will be held securely at Teesside University in accord with the Data Protection Act (1998). Only people directly involved in this evaluation will hear and see these. All data will be anonymised and held for up to 6 years and may be used for future study but only in research projects that have received ethical approval from an appropriate committee.

Are there any risks involved in taking part?

NO risk is expected to those taking part in this study. You are free to choose if you want to take part and no one will pressure you. No sensitive questions will be asked at any point and no one will judge you.

What happens next?

If you want to take part in this study then please contact Dora Machaira, the lead researcher via telephone/text (01642) 384996, [mobile number to be confirmed] or e-mail t.machaira@tees.ac.uk.

I want to thank you for reading this leaflet. If you want to speak with someone who knows about the study but not directly involved in it, or if you have any complaints or comments you may contact:

Alasdair MacSween Ph.D B.Sc.(Hons) MCSP

Chair of School of Health & Social Care Research Governance and Ethics Committee

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Email: A.Macsween@tees.ac.uk

Appendix F. *Consent form parents*

Evaluation of 'A Fairer Start'

Researcher: Dora Machaira

Please read the following statements and sign your initials in the appropriate boxes to show you agree for the study to take place.

I confirm that:

I have read and understood the information sheet dated [insert date] and have had the opportunity to ask questions. ☐

I understand that taking part in this interview is voluntary. ☐

I understand that I can leave the discussion at any time without having to give a reason. ☐

I understand that the discussion will be recorded and then written down. ☐

I understand that any information I give today will be kept confidential and that no personal information that may identify me will be used in the final written reports. ☐

I understand that the recording of my interview and all paper documents relating to it will be held securely at Teesside University in accord with the Data Protection Act (1998). ☐

Only those directly involved in this evaluation will hear and see these. All data will be anonymised and held for up to 6 years and may be used for future study (secondary analysis) but only in research projects that have received ethical approval from an appropriate committee.

I agree to take part in the interview. ☐

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Name Date Signature

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Name of Researcher Date Signature

Appendix G. Email to request the document included in the analysis

Dear INSERT NAME,

Volunteering in early years interventions: a case study

As you are aware the "Evaluation of A Fairer Start" which your organisation took part in, has now been completed. A PhD level study was being carried out alongside the evaluation as agreed in the commission of Teesside University to undertake the evaluation. It has now become apparent that in order to fulfil the aims and answer the research questions of the PhD, the successful tender response from Big Life Families to Catalyst would be helpful. The PhD study has received ethical clearance from the School of Health & Social Care Ethics Committee at Teesside University.

The PhD thesis reports on the Community Champions Volunteer Programme as developed and implemented by Big Life Families and therefore the researcher requires as much information as possible about it. The information sheet attached to this email answers questions around the study and provides more information around how the tender document will be used, should you agree to provide it to the researcher. Please take the time to read this carefully as it provides further details about the project, its aims and the methods to be used. If you have any questions about this invitation, please do contact me and I will be happy to answer those.

If, after you read the attached Participant information Sheet, you are happy for the tender document to be released for analysis and reporting (as detailed), please complete and return the attached study Consent Form to t.machaira@tees.ac.uk.

If - both - Catalyst and Big Life Families agree to release the tender document, for analysis and reporting, and - both - Catalyst and Big Life Families return a completed Consent Form, we will then contact you to confirm that and arrange transfer of the document.

Please note that both organisations must agree, or the document cannot be released to TU; so please do not send the tender document to us until we confirm that both organisations have given Informed Consent.

Yours sincerely

Dr Liane Azevedo

Senior Lecturer in Physical Activity

Teesside University

Appendix H. Information sheet for the document

Volunteering in early years interventions: a case study

PhD student: Miss Theodora Machaira

Director of Studies: Dr Liane Azevedo

Supervisors: Professor Raghu Lingam, University of South Wales, Australia, Professor Paul Crawshaw, Teesside University,

Dr Peter van der Graaf, Teesside University

This information sheet has been designed to provide you with enough information to help you make an informed decision as to whether you wish to provide the tender document to be used in the above study. It will explain what the project is about, what it aims to find out and how the document will contribute to that.

What is the purpose of this study?

The purpose of this study is in part fulfillment of the requirements for Dora Machaira's PhD. studies at Teesside University. The overall aim, of this part of Dora's PhD, is to explore what volunteering is and how it works in an early years volunteer programme, through examining professionals', volunteers' and parents' accounts. More specifically, it aims to answer the following research questions:

- What is the underlying Theory of Change for the volunteer programme under investigation?
- To what extent did the volunteer programme build community assets?

- To what extent did the volunteer programme enable professionals' work?
- To what extent did the volunteer programme benefit parents?

Why would I like the tender document?

The tender document will provide Dora with an understanding of the underlying theory of the volunteer programme. In that document, the volunteer programme is outlined in detail, including its aims and objectives. Having that document, in addition to the interviews already conducted as part of the evaluation, will help Dora understand the ideas behind the programme.

How will information be collected?

The information that will be used from the document will be around the inception of the programme; what it aimed to achieve and how it aimed to achieve it.

What will I be asked to do?

We are asking you to give your consent for the tender document to be sent to Dora and included in the analysis.

How will the information be used?

The tender document will be used in the PhD thesis that will be produced. In addition to the thesis, it is anticipated that the findings from this study will be written up for peer-reviewed journal publication and presented at appropriate conferences.

Do I have to provide you with the document?

NO. You are free to choose whether or not you wish Dora to obtain and analyse the document.

Will the document remain confidential?

YES. No personal details (including your name or your job role) will be disclosed in any report that is written. However, given the fact that only two organisations were involved in the volunteer programme and the nature of the tender document, anyone who knows (or knew) about the programme and/or the tender process, will be very likely to know which organisations were involved. As a result, as you make your decision about whether or not to release the documents, for analysis and reporting, you should consider that, while TU will treat the document and the findings (and any related materials), with the utmost respect and care, these will not be held, accessed nor processed as confidential documents under the GDPR or the DPA (2018). Consequently, TU cannot give you any guarantees of confidentiality, nor anonymity. You are advised to consider that the document you release and the results/data etc. of Dora's PhD. will effectively be in the public domain, in an identifiable format, with respect to TU, the student and your organisations. Nevertheless, Dora will combat this as much as possible during the reporting phases.

All study activities will be compliant with the General Data Protection Regulation and the Data Protection Act 2018 (https://www.eugdpr.org/). If both Catalyst and Big Life Families agree to release the tender document it will be held securely at Teesside University and all electronic format data will be held on a password protected TU server. Only staff directly involved in this study will see it. All data will be anonymised and held for up to 6 years and may be used for future study but only in research projects that have received ethical approval from an appropriate committee. The non-identifiable research data will be stored indefinitely on a secure password protected server at Teesside University. This is in case other scientists wish to raise questions about the results that need checking against the dataset. In the event that the study is published in a scientific journal, the non-person identifiable research dataset may be made publicly available (for example, as a supplement to the journal article, or stored on an on-line scientific data repository).

Personal data including special category data obtained for the purposes of this research project is processed lawfully in the necessary performance of scientific or historical research or for statistical purposes carried out in the public interest. Processing of personal data including special category data is proportionate to the aims pursued, respects the essence of data protection and provides suitable and specific measures to safeguard the rights and interests of the data subject in full compliance with the General Data Protection Regulation and the Data Protection Act 2018.

Are there any risks involved in giving you my consent?

NO. Both Catalyst and Big Life Families are free to choose whether or not they wish to release the tender document for analysis and reporting. Both organisations must agree, or the document cannot be released.

What happens next?

If you are happy to give your consent for the document to be included in the study then please email the completed consent form to Dora Machaira, the researcher via e-mail t.machaira@tees.ac.uk.

I would like to take this opportunity to thank you for taking the time to read this information sheet. If you wish to speak with someone who knows about the study but not directly involved in it, or if you have any complaints or comments you may contact:

Alasdair MacSween Ph.D B.Sc.(Hons) MCSP

Chair of School of Health & Social Care Research Governance and Ethics Committee

School of Health & Social Care

Teesside University

Middlesbrough

TS1 3BA

Tel: (01642) 342965

Email: A.Macsween@tees.ac.uk

Appendix I. *Consent form for the document*

Volunteering in early years interventions: a case study

PhD student: Miss Theodora Machaira

Director of Studies: Dr Liane Azevedo

Supervisors: Professor Raghu Lingam, University of South Wales, Australia, Professor Paul Crawshaw, Teesside University,

Dr Peter van der Graaf, Teesside University

Please read the following statements and indicate your agreement by signing your initials in the appropriate boxes to grant permission for the study to take place.

I confirm that:

☐ I have read and understood the information sheet dated 30/11/2018 and have had the opportunity to ask questions.

☐ I understand that giving my consent to include the tender response in the PhD analysis is voluntary.

☐ I understand that excerpts from the document may be used in the PhD thesis.

I understand that any personal information in the document will be kept confidential and that no personal information that may identify me will be used in the final written reports. ☐

I understand that the tender response document and all study activities will be compliant with the General Data Protection Regulation and the Data Protection Act 2018 (https://www.eugdpr.org/). If both Catalyst and Big Life Families agree to release the tender document it will be held securely at Teesside University and all electronic format data will be held on a password protected TU server. ☐

I agree for the document to be sent to the researcher and analysed for the purposes of the PhD. ☐

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Name Date Signature

Appendix J. Ethical approval letter for the evaluation of AFS

Teesside University
Middlesbrough Tees Valley
TS1 3BA UK
www.tees.ac.uk

Teesside University

PRIVATE AND CONFIDENTIAL

Direct Line: 01642 342750

27/07/2015

Janet Shucksmith
School of Health & Social Care
Teesside University

Dear Janet,

Study No 148/15 – Evaluation of 'A Fairer Start' in Stockton. Researcher: Miss Theodora Machaira. Supervisor: Professor Janet Shucksmith.

Decision: Approved with Conditions

Thank you for your application to the School of Health & Social Care Research Governance and Ethics Committee. The application was presented on a *TU Request for Ethical Approval form*.

The Committee reviewed and approved your application on 16/07/2015 and your study may proceed as it was described in your application pack, **on the condition that the comments detailed in the table below are addressed:**

Thank you for submitting amended documents – we have reviewed the amended documents and this opinion refers to those. Please note this opinion does not cover the Secondary Analysis referred to in Section 12 which you stated will submitted for review on a separate Release Form.
Conditions
Appendix 1: Include the academic supervisor's contact details.
Appendices 3, 4 and 6: In the opening invitation paragraph please tell people by whom they have been contacted and that whoever that is has contacted them on behalf of the student and that the student does not know who has been contacted and that no one's contact details or any information about them has been released to or accessed by the student.
Appendix 4: • Please ensure that the telephone number given is not a personal number and is either a work number which may be used for this study, or, a dedicated study number that has never, and will never, be used for any other purpose. • Please make it clear that participants must not name any specific people nor give any information that could render anyone or any site identifiable and if they do that data will be destroyed and not included in the analysis.
Appendix 7: Please make it clear that participants must not name any specific people nor give any information that could render anyone or any site identifiable and if they do that data will be destroyed and not included in the analysis.
Advisory

Appendix K. Ethical release letter for secondary data analysis

Teesside University
Middlesbrough Tees Valley
TS1 3BA UK
www.tees.ac.uk

Teesside University

PRIVATE AND CONFIDENTIAL

Direct Line: 01642 384124

08/11/2018

Liane Azevedo
School of Health & Social Care
Teesside University

Dear Liane

Study R149/18: Volunteering in early years interventions: a case study. Researcher: Dora Machaira: Supervisor: Liane Azevedo.

Thank you for submitting an application for Ethical Clearance via a Research Ethics Release Form.

I have **reviewed** and **approved** your application on 08/11/2018 and your study may proceed as it was described in your application pack, subject to your meeting the Conditions detailed below.

Re all documents

INSERT TEESSIDE UNIVERSITY LOGO

Under Teesside University Policy students are not allowed to use the University's logo on any documents. If a student wishes/needs to use the logo their academic supervisor should request permission to use the specially amended version of the logo for use on student materials from Dr Andrew Rawnsley at R&IS (giving the name of the project and student concerned). Once Dr Rawnsley has confirmed permission that logo may be used on the final approved version of the documents concerned (if you do not already have a copy of the student logo on file please contact Dr Rawnsley at R&IS and he will send you one).

Appendix 2: Email to Catalyst and Big Life Families

Please delete the text

This information should give enough detail so that you are able to make an informed decision as to whether you are happy to provide the document or not.

and replace it with

Appendix L. Biopics of three volunteers and a mother

Biopic 1: John and Lisa (asylum seeking volunteers)

John (pseudonym) came to the UK three years prior to his involvement in the FSVP (2013) with his then pregnant wife Lisa (pseudonym). They were both from Pakistan and were seeking asylum in the UK. Due to the fact that they did not have the right to work in the UK, they looked for opportunities to volunteer as they were not comfortable with unemployment. They were both professionals in Pakistan working for over 10 years in paid employment prior to migrating. John was an IT expert and Lisa was a HR officer working for an international corporation.

After going to the children's centre for Lisa's midwife appointment, they saw the advertisements for the FSVP. Having both been volunteers previously, and due to the fact they wanted to understand the system of employment in the UK, they decided to volunteer as part of the FSVP. Both John and Lisa were Christian Catholic and were involved in the local church as volunteers. Their culture revolved around family, and because they had to leave their extended family behind when they left their country, they found a new family in the local church and children's centre.

John had volunteered previously in homes for the elderly, prisons and the church so he was an experienced and dedicated volunteer. In Stockton, John and Lisa were volunteers for the church and the FSVP. As part of their volunteering in the FSVP they attended a six week training programme and they were taking part in other training around parenting skills. They were initially ambassadors for the FSVP, trying to raise awareness around it and they used both volunteering sites to do so. They promoted FSVP by using fliers and conversations with people in the church as well as in conversations with people in the children's centres. They also took

on more responsibilities; John facilitated stay and play sessions in the children's centres and Lisa worked with health visitors to visit hostels housing refugees and asylum seekers.

John and Lisa struggled with the inability to work in the UK. They both claimed that they had the skills, experience and qualifications to be able to excel at a paid post but their circumstances did not allow it. John was offered a paid position through his volunteering at the children's centre which he had to turn down as it would have been illegal. This added to the frustration he was feeling. John felt that volunteering was a rewarding experience but given his circumstances, he felt that he would have benefitted from some incentives or rewards for his time.

Biopic 2: Mary (British volunteer)

Mary (pseudonym) was a British mother with two daughters. She had recently started volunteering for the FSVP at the time of the interview. She was attending College studying for a Health and Social Care qualification and some training programmes at the children's centre from with the FSVP operated. Mary had her first daughter when she was 16 and had social care involvement. Her first daughter had complex needs which Mary could not cope with. Although at the time social services wanted her to take advantage of services in children's centres, Mary had mental health issues and refused to do so. This led to social services removing her daughter and placing her into foster care. When she fell pregnant with her second daughter social services were concerned and Mary had to fight not to lose her second child. A requirement from social services in order to keep her daughter was that she had to attend a training course delivered in the children's centre. It was there that the team leader for volunteers suggested that Mary could do excellent work with families and asked her to volunteer.

Mary volunteered as an outreach volunteer; she conducted visits alongside a children's centre professional trying to engage disengaged families with children's centres. She was given a

choice as to what she wanted to do with her time when volunteering and she decided to do outreach work rather than children's centres based work. Mary aspired to work with children and families in the future, not necessarily as a social worker but trying to prevent social care involvement. Mary felt that her volunteering was something that she did to better herself, to improve her personal circumstances so that she could provide for her daughter and potentially fight to get her looked after daughter back.

Mary had never had a job up to that time; she felt that her experiences, particularly her involvement with social services and her mental health issues, were what made her a great volunteer. Given her past experiences, Mary understood that people may not want to speak to a professional or feel intimidated by them (similarly to the way she felt when she had her first child) but she felt that they could relate to her.

Mary had attended a six week training course prior to her volunteering in the FSVP and regularly attended other courses to develop herself. She was paired with an outreach worker from the children's centre and was supervised during all visits.

Biopic 3: Claire (asylum seeking mother)

Claire (pseudonym) was a mother of four at the time of the interviews. She had fled Iran, her home country, to avoid getting married to a man her family wanted her to marry. Her and her husband decided to leave Iran and request asylum in the UK. Her eldest child was 13 years old and her youngest was 11 months old. Two of her children were born in the UK. She first left Iran 15 years prior to the interview and had had to migrate in different countries across Europe before settling in the UK. She first settled in Middlesbrough five years prior to the interview (2012) from where she had to be moved due to attacks to her home. She was then moved to Stockton-on-Tees where her health visitor recommended the children's centre from where the FSVP operated. Her health visitor accompanied her to her first visit to the centre and made sure

that she knew where it was, what sessions she could attend and who to contact should she needed any help. Claire quickly made friends in the centre as there were women from similar backgrounds to her. Claire struggled with the language so she was attending English language courses at the centre.

Claire described her experiences of racism in Middlesbrough and got emotional about the fact that she and her family were abused because they were migrants. She talked about her sadness and her constant fear of attacks by people. In a previous attack, someone tried to burn her house down with her and her children in it and therefore she was terrified of this happening again. Given these past experiences, Claire was very happy with her new home in Stockton and was particularly grateful to her health visitor, the children's centre and the local community as she felt supported.

Claire and her husband were not allowed to work in the UK due to the fact they were asylum seekers. Although they were asylum seekers for 5 years by that point, no progress had been made with their application as, according to Claire, the British government did not believe they were in danger in Iran. Claire however, mentioned that she could not go back as her family would kill her for running away with her husband.

She was very frustrated as she wanted to go to college, gain qualifications and work but the poverty she and her family had to face coupled with the legislation around asylum seekers in the UK meant that she could not. Both her and her husband wanted to be able to provide for their family but could not which added to their sadness. Her children inadvertently added to those frustrations as they were asking for holidays, new clothes, shoes etc. which Claire and her husband could not provide.

Claire and her younger children attended the children's centre regularly as it helped Claire make friends, get out of the house and feel less isolated and it helped her children socialise and

improve their English. Claire was very keen to volunteer to reciprocate the help and support she received from the centre and the health visitors. She was due to start the six week training course at the time of the interview.

Appendix M. COREQ Checklist

No. Item	Guide questions/description	Reported on page
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Theodora Machaira	1
2. Credentials	At the time of interviews I had a BSc (Hons) in Psychology, a PGDip in Psychology and an MSc in Health Psychology	10
3. Occupation	I was a full time PhD researcher	10
4. Gender	Female	10
5. Experience and training	I had successfully completed two qualitative dissertations using Interpretative Phenomenological Analysis and Discourse Analysis. I had extensive training in qualitative research methods as part of my qualifications and I had worked as a qualitative researcher for a local authority and an academic institution for two years prior to commencing the study.	10-11
Relationship with participants		
6. Relationship established	Relationships were established with some participants. I had met all strategic stakeholders prior to the interviews and some frontline professionals. I had met all volunteers and mothers prior to interviewing them.	100 105-107
7. Participant knowledge of the interviewer	All participants had consistent information about me through the participant information sheets. They knew that I was conducting an evaluation and a PhD and the reasons for this. All participants consented for their information to be used for both pieces of work.	105-107 Appendices A, B, D, E

8. Interviewer characteristics	I reflected on my own bias, previous experiences and personal characteristics relevant to the study throughout the thesis. These are reported in different sections depending on relevance.	9-11 97-98
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	Qualitative intrinsic case study methodology was adopted.	98
Participant selection		
10. Sampling	The sampling strategy was purposive in accordance with case study methodology.	105
11. Method of approach	Participants were approach through various methods. Strategic stakeholders and frontline professionals received emails about the study and responded to me directly. Volunteers and mothers were informed through participant information sheets that were available at children's centres where they congregated. Volunteers and mothers were also approached face to face as I was present in children's centres to aid recruitment.	105-107
12. Sample size	Forty-four	108
13. Non-participation	22 strategic stakeholders were invited and 14 agreed to participate. 74 frontline professionals were invited and 12 agreed to take part in the study. Approximately 30 volunteers supported the programme and therefore were at the children's centre where information about the study was displayed. 9 came forward for an interview. It is hard to estimate how many parents saw the information about the study but 4 wanted to participate. No reasons were given for non-participation by any of the participants who	108-110

	did not agree to participate. No one dropped out or requested for their data not to be used.	
Setting		
14. Setting of data collection	All data were collected at participants' place of work or at the children's centres (for volunteers and mothers). Some data were collected through telephone interviews at participants' request.	107
15. Presence of non-participants	Only the researcher and the participants were present at each interview/focus group.	107
16. Description of sample	The sample has been thoroughly described in the relevant sections of the methodology.	107-111
Data collection		
17. Interview guide	The interview guide was developed by the researcher and piloted in 2 scoping focus groups and 1 interview with strategic stakeholders. The interview guide for volunteers and mothers was broad enough to ensure that rich conversations could be had. This was not pilot tested due to time constraints.	104
18. Repeat interviews	Three interviews and 2 focus groups were repeated towards the end of the project with strategic stakeholders (end of 2017). Given the fact that interviews with volunteers and mothers were conducted relatively late in the project (September/October 2017) no repeated interviews took place.	108
19. Audio/visual recording	Audio recording was used for all interviews/focus groups with participants' consent. The recordings were destroyed following transcription of the interviews/focus groups and the transcripts are held in a password protected computer.	107

20. Field notes	No notes were made during or after the interviews/focus groups. Field notes were made after events/sessions that the researcher attended. No names were recorded in the field notes.	100-101
21. Duration	All interviews and focus group ranged from 15 minutes to 2 hours.	107
22. Data saturation	Data saturation was reached with strategic stakeholders, frontline professionals and volunteers. The themes that came up from these groups were consistent throughout the interviews/focus groups. Data saturation was not reached with mothers given the small number of participants (4). Unfortunately it was not possible to interview more mothers because the participation in the programme was low.	108-111
23. Transcripts returned	Transcripts were not returned to participants.	107
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	The PhD researcher coded the data. Once the data were coded, they were discussed with the supervisory team during supervision meeting so that they could be refined.	113-115
25. Description of the coding tree	Although not a coding tree as such, the data were initially divided by professional group (strategic stakeholders, frontline professionals, volunteers and mothers). Once themes from all the groups were identified, these were contrasted to themes from other groups and commonalities were identified before finalizing the themes from the full analysis.	113-115
26. Derivation of themes	All themes were derived from the data. Literature search and reading took place after analysis to	113-115

	ensure true deductive approach	
27. Software	NVivo software was used to manage and analyse the data	114
28. Participant checking	Participants did not provide feedback on the findings as by the time the findings had been produced, the programme had been decommissioned and participants could not be found.	117-118
Reporting		
29. Quotations presented	Yes, all themes and subthemes were supported by participant quotes.	Chapters 6 and 7
30. Data and findings consistent	Yes	Chapters 6 and 7
31. Clarity of major themes	Yes	Chapters 6 and 7
32. Clarity of minor themes	Yes	Chapters 6 and 7